RA395
.U522
1947/48
S
pt.5

Library
National Institutes of Health
Bethesda 14, Maryland

TIONAL HEALTH PROGRAM

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

EIGHTIETH CONGRESS
SECOND SESSION

ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 5

JANUARY 30, FEBRUARY 4, 5, MAY 25, 26, 27, 28,
AND JUNE 1, 1948

Printed for the use of the Committee on Labor and Public Welfare

Library
National Institutes of Health
Bethesda 14, Maryland

NATIONAL HEALTH PROGRAM

U.S. Congress. Senate, Com on Labor and Public welfare

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

EIGHTIETH CONGRESS
SECOND SESSION
ON

S. 545

A BILL TO COORDINATE THE HEALTH FUNCTIONS OF THE FEDERAL GOVERNMENT IN A SINGLE AGENCY; TO AMEND THE PUBLIC HEALTH SERVICE ACT FOR THE FOLLOWING PURPOSES: TO EXPAND THE ACTIVITIES OF THE PUBLIC HEALTH SERVICE; TO PROMOTE AND ENCOURAGE MEDICAL AND DENTAL RESEARCH IN THE NATIONAL INSTITUTE OF HEALTH AND THROUGH GRANTS-IN-AID TO THE STATES; TO CONSTRUCT IN THE NATIONAL INSTITUTE OF HEALTH A DENTAL RESEARCH INSTITUTE; AND FOR OTHER PURPOSES

AND

S. 1320

A BILL TO PROVIDE A NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH PROGRAM

PART 5

JANUARY 30, FEBRUARY 4, 5, MAY 25, 26, 27, 28,
AND JUNE 1, 1948

Printed for the use of the Committee on Labor and Public Welfare

UNITED STATES
GOVERNMENT PRINTING OFFICE
WASHINGTON : 1948

64431

FEB 21 '49
12/31/48 JB

RA395
.U522
1947/48
S
pt.5

COMMITTEE ON LABOR AND PUBLIC WELFARE

ROBERT A. TAFT, Ohio, *Chairman*

GEORGE D. AIKEN, Vermont
JOSEPH H. BALL, Minnesota
H. ALEXANDER SMITH, New Jersey
WAYNE MORSE, Oregon
FORREST C. DONNELL, Missouri
WILLIAM E. JENNER, Indiana
IRVING M. IVES, New York

ELBERT D. THOMAS, Utah
JAMES E. MURRAY, Montana
CLAUDE PEPPER, Florida
ALLEN J. ELLENDER, Louisiana
LISTER HILL, Alabama

PHILIP R. RODGERS, *Clerk*

SUBCOMMITTEE ON HEALTH

H. ALEXANDER SMITH, New Jersey, *Chairman*

JOSEPH H. BALL, Minnesota
FORREST C. DONNELL, Missouri

JAMES E. MURRAY, Montana
CLAUDE PEPPER, Florida

CONTENTS

I. ALPHABETICAL LIST OF WITNESSES

Page

Falk, I. S., Director, Bureau of Research and Statistics, Social Security Administration ---- 2369

Shearon, Mrs. Marjorie, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2217, 2325, 2400, 2471, 2526, 2573

II. CHRONOLOGICAL LIST OF WITNESSES

Friday, January 30, 1948:
- Mrs. Marjorie Shearon, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2217

Wednesday, February, 4, 1948:
- Mrs. Marjorie Shearon, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2325

Thursday, February 5, 1948:
- I. S. Falk, Director, Bureau of Research and Statistics, Social Security Administration ---- 2369

Tuesday, May 25, 1948:
- Mrs. Marjorie Shearon, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2400

Wednesday, May 26, 1948:
- Mrs. Marjorie Shearon, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2471

Thursday, May 27, 1948:
- Mrs. Marjorie Shearon, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2526

Tuesday, June 1, 1948:
- Mrs. Marjorie Shearon, Ph. D., director, Shearon Medical Legislative Service, Washington, D. C ---- 2573

III. Statements and Communications

Donnell, Hon. Forrest C., a United States Senator from the State of Missouri, insertions of—
- American Medical Association Journal, May 3, 1948, editorial from, the National Health Assembly ---- 2411
- Committee for the Nation's Health, statement of, May 13, 1948, on Brookings Institution report ---- 2561
- Falk, Isidore S., Director, Bureau of Research and Statistics, Social Security Administration, memorandum of, Administration for the Medical Care and Hospitalization Benefits Under the Wagner-Murray-Dingell Bill (S. 1161) ---- 2631
- Harness, Hon. Forest A., chairman, Subcommittee on Publicity and Propaganda, House Committee on Expenditures in Executive Departments, letter of, to Congressman Taber, chairman, House Committee on Appropriations, in re special health mission to Japan ---- 2532
- Health Subcommittee, Senate Committee on Labor and Public Welfare, committee print of, Medical Care for the Individual ---- 2441
- Lawrence, Joseph S., M. D., telegram to, from A. C. Callister, M. D., chairman, Utah State Board of Health, in re opposition to S. 1320 ---- 2367
- Meriam, Lewis, The Brookings Institution, A Summary of the Publication Relief and Social Security, October 1946, pp. 30–32 ---- 2565
- Moulton, Dr. Harold C., The Brookings Institution, letter from, to Mr. Robert Perkins Bass, Orchard Hill Farms, Peterborough, N. H., commenting on Mr. Bass' letter to him ---- 2566

Donnell, Hon. Forrest C.—Continued Page
  Moulton, Dr. Harold G., The Brookings Institution, letter to, from Morris L. Cooke, Washington, D. C., enclosing copy of letter from Mr. Cooke to Hon. Robert P. Bass, chairman of the board of The Brookings Institution, Peterborough, N. H., in re Brookings Institution report ---- 2564
  Newspaper clippings, as follows:
    The Christian Science Monitor, March 15, 1948, Impartial Report- 2563
    The Christian Science Monitor, May 26, 1948, Brookings Institution Piles Up Points Against State Medicine---- 2650
    The New York Times, May 17, 1948, Four Doctors Assail Brookings Report—Health Committee Members Deny Physician Shortage and Call Study "Bias"---- 2568
    The Washington Post, May 25, 1948, National Debt of 252 Billions May Be Boosted, Snyder Says---- 2526
  S. 1606, letter of transmittal in re, addressed to members of the Senate Committee on Education and Labor by Senator Murray---- 2364
  Senate committee print No. 5, July 1946, excerpt from, Chapter V—Methods of Paying Physicians---- 2380
  Senate committee print No. 5, July 1946, introductory note of, by Senator Murray---- 2358
  Shearon, Mrs. Marjorie, Ph. D., director, Shearon Medical Legislative Service, document presented by, Comparison of Wagner Bill (S. 1161), With Social Security Board Bill---- 2626
  Whitney, A. F., president, Brotherhood of Railroad Trainmen, excerpt from circular letter by, in re establishment of Public Affairs Institute ---- 2586
Falk, Isidore S., Director, Bureau of Research and Statistics, Social Security Administration, insertions of—
  Shearon, Mrs. Marjorie, Ph. D., letter of, addressed to Social Security Administration, requesting that her name be added to their mailing list---- 2374
  Shearon, Mrs. Marjorie, Ph. D., letter to, from W. L. Mitchell, Acting Commissioner for Social Security, in reply to Mrs. Shearon's letter re mailing list---- 2374
Murray, Hon. James E., a United States Senator from the State of Montana, insertions of—
  Chicago Institute of Medicine, statement issued by, Institute of Medicine Award of Citizen Fellowship to Albert Davis Lasker---- 2189
  Clark, Dean A., M. D., medical director, Health Insurance Plan of Greater New York, letter of, to Senator Murray, enclosing clippings in re health insurance---- 2694
    New York Herald Tribune, May 20, 1948, Doctors Urged by Society to boycott H. I. P.—State Medical Group Says They Should Join Only in Six Plans It Approves---- 2695
    New York Times, May 20, 1948, by William L. Laurence, State Doctors Get Warning on "Plans"—Medical Society "Advises" Them Against Participating in Any It Has Not Approved—Only Six Endorsed So Far—Blow Seen to City-Sponsored Project—Hospitals "Practicing Medicine" Are Assailed---- 2696
    Watertown Daily Times, May 25, 1948, Doctors and Progress---- 2697
    Rappleye, Willard C., M. D., chairman, board of directors, Health Insurance Plan of Greater New York, statement of, in re health insurance ---- 2698
    New York State Journal of Medicine, July 15, 1947, by George P. Farrell, Standards for Approval of Medical Society of the State of New York of Voluntary Nonprofit Medical Care Plans in New York State---- 2698
    New York Herald Tribune, May 22, 1948, A Step Backward---- 2700
    New York Times, May 21, 1948, A Sound Health Plan---- 2700
  Falk, I. S., Director, Bureau of Research and Statistics, Social Security Board, letter of, to Senator Murray, in re testimony of Mrs. Marjorie Shearon---- 2368
  Falk, I. S., Director, Bureau of Research and Statistics, Social Security Board, comments of, in re Mrs. Marjorie Shearon's testimony- 2690

Murray, Hon. James E.—Continued — Page
Letter of, dated May 27, 1948, to Senator Smith, in re certain insertions in record of the health hearings — 2525
Letter of, to Senator Smith, transmitting material in re the National Physicians Committee, including a memorandum entitled, "The National Physicians Committee" and eight attachments as follows — 2666
NPC attachment 1:
Memorandum to Members of the Board of Directors of the National Physicians Committee, by Marjorie Shearon, Ph. D — 2667
NPC attachment 2:
Excerpts from Report on Public Relations to the trustees of the American Medical Association, June 15, 1946, Relations With the National Physicians Committee — 2670
NPC attachment 3:
The New York Post, December 31, 1947, Physician Lobby Uses Red Herring Lies in Battle on National Health Insurance — 2671
NPC attachment 4:
National Physicians Committee for the Extension of Medical Service Schedule of Contributions—$500 or more year ended December 31, 1947 — 2672
NPC attachment 5:
The Journal of the American Medical Association, December 20, 1947, Medical Services Foundation Dissolved — 2672
NPC attachment 6:
The Washington Star, March 30, 1948, On the Other Hand—American Medical Association's Attempt to Influence Cartoonists, by Lowell Mellett — 2673
The Washington Post, May 7, 1948, Press Bribery — 2674
Editor and Publisher, May 1, 1948, Senator Murray Flays "Vicious" Cartoon Prizes — 2674
Public Relations News, New York, letter No. 197, April 19, 1948 — 2675
NPC attachment 7:
Speech of Hon. James E. Murray, of Montana, in the Senate of the United States, April 26, 1948, Efforts to Undermine the Press — 2675
Editor and Publisher, February 28, 1948, Announcing Cash Awards for Cartoonists—Fourteen Important Awards — 2679
Editor and Publisher, March 6, 1948, Questionnaire Contest — 2680
Editor and Publisher, March 13, 1948, letter to, from Ralph L. Crosman, director, College of Journalism, University of Colorado, in re newspaper cartoonists' contest — 2680
Editor and Publisher, March 20, 1948, To Editors from Doctors, paid advertisement which appeared in — 2681
The Washington Star, March 30, 1948, American Medical Association's Attempt to Influence Cartoonists, by Lowell Mellett — 2682
NPC attachment 8:
Shoulders, Dr. H. H., president, American Medical Association, Western Union night letter to, June 8, 1947, from Senator Murray, in re National Physicians Committee — 2683
Look Magazine, June 22, 1948, My Plan for Health Insurance—It May Make the Golden State the First to Banish the Ruinous Cost of Serious Illness, by Gov. Earl Warren, of California — 2686
MacLean, Hugh, M. D., F. A. C. S., and McHenry, Dean E., Ph. D., Los Angeles, Calif., 1947, article by, Health Services in New Zealand — 2200
Marciniak, Edward A., article by, from American Catholic Sociological Review, October 1947, Public Health Insurance in the United States — 2189
Mattingly, Thomas, M. D., Washington, D. C., letter of, to editor of the Washington Star, criticizing S. 545 — 2215
New York Times, June 1, 1948, Sees Health Plans on a 3-year Trial—Dr. Hawley, Blue Cross-Blue Shield Executive, Says Failure May Mean United States Program — 2685

Murray, Hon. James E.—Continued Page
  Pepper, Hon. Claude, a United States Senator from the State of Florida, and Senator Murray, letter of, addressed to Senator Smith, transmitting letter to Senator Murray by Michael M. Davis, chairman, Committee on Research and Medical Economics, and Dewey Anderson, executive director, Public Affairs Institute, enclosing a report entitled, "Medical Care of the Individual and the Issue of Compulsory Health Insurance" 2452
  Statement of, The AMA Can't Afford Blue Cross 2684
  Statement of, in re Republican Governor Warren's stand on health insurance 2685
Shearon, Mrs. Marjorie, director, Shearon Medical Legislative Service, Washington, D. C., insertions of:
  Addresses, articles, memoranda, statements, and publications of:
    Boas' Affiliations With Communist Organizations, paper submitted by 2558
    Bureaucratic Control of Medicine, address of 2223
    Bureaucratic Control of Medicine, publication of 2516
    Committee for the Nation's Health, April 2, 1946, paper of 2581
    Dr. Fishbein Sends Congratulations to Ewing on Success of Health Assembly, statement of 2412
    Estimated Per Capita Cost of Benefits Under Farbstein, Ives, and Austin Bills, and for Complete Benefits With Estimated Total Cost of Complete Benefits, statement of (with table furnished by the National Industrial Conference Board) 2509
    Federal Propaganda for the Welfare State, publication of 2535
    Memorandum of, in re background information on William G. Reidy 2582
    Memorandum of, in re Crain letter and telegram sent to Mr. Crain by Dr. Parran 2622
    Memorandum of, in re letter from Thomas Parran, Surgeon General, to Kenneth C. Crain, vice president, eastern editor, Hospital Management, New York, N. Y., about Wagner-Murray-Dingell bill 2621
    Memorandum of, to Mr. Perrott, Federal Security Agency, in re comparison of Wagner bill (S. 1161) with the Social Security Board draft bills, dated March 8 and May 25, 1943 2623
    National Health Assembly—Greatest Nonpolitical, Nonlobbying, Charitable Meeting of Its Kind Ever Held in Washington—Medical Care Section Run by Same Organized Minority That Rigged APHA Platform in 1944, statement of 2437
    National Health Assembly, Inc., Turns Out To Be Political Scheme as Predicted, statement of 2415
    New Zealand's Free Medical Benefits, publication of 2482
    Paradise Unlimited: The Menace of the Police State, article by 2502
    Proposed 10-Year Postwar Program of the United States Public Health Service, a document prepared for Thomas Parran, M. D., Surgeon General, United States Public Health Service 2235
    S. 1050, digest of, submitted by 2299
    S. 1606, digest and critique of, submitted by 2302
    Regulative Interference Under the Wagner-Murray-Dingell bills, publication of 2329
    Final statement of, in reply to I. S. Falk's comments on the testimony of Dr. Shearon 2727
    Testimony of Marjorie Shearon, Ph. D., before the Health Subcommittee of the Senate Committee on Labor and Public Welfare at the hearings on S. 545 and S. 1320, brief submitted by 2650
    Testimony of, at Senate hearings on H. R. 6355, supplemental FSA appropriation bill, fiscal year 1949 2420
    Unmet Health Needs, a paper presented before the American Public Health Association, October 4, 1944, excerpt from 2494
  Other materials:
    Altmeyer, A. J., Commissioner for Social Security, statement submitted by, before the Advisory Council on Social Security, Senate Finance Committee, December 4, 1947 2309

Shearon, Mrs. Marjorie—Continued Page
Other materials—Continued
Ball, Hon. Joseph H., a United States Senator from the State of Minnesota, speech of, on the floor of the Senate, July 9, 1947, Labor-Management Relations—Minority Views Presented by Mr. Pepper 2584
Cruikshank, Nelson, AFL, statement introduced by, at National Health Assembly, Inc., May 3, 1948, Statement of Immediate Goals for National Health Security 2434
Cruikshank, Nelson, AFL, copy of revised statement for National Health Assembly, May 1–4, 1948 2435
Friedman, Dr. Maurice, article by, from Nation's Business, May 1948, Doctor, My Statistics Feel Funny 2643
Full independent slate of officers for New York County Chapter of Physicians' Forum, May 24, Academy of Medicine, New York, N. Y. 2574
Harness, Hon. Forest A., a Representative in Congress from the State of Indiana, extracts from address of, February 15, 1948, in re health mission to Japan 2593
List of contributors of more than $500 to Committee for the Nation's Health 2580
National Health Assembly, certificate of incorporation 2401
National Health Assembly, list of executive committee members, February 13, 1948 2406
National Health Assembly, list of executive committee members, May 1–4, 1948 2406
National Health Assembly, resolution on, submitted by Joseph C. Bunten, M. D., speaker, AAPS House of Delegates, May 15, 1948 2568
Newspaper clippings as follows:
New York Times, May 25, 1948, Woman Nominated as Member of FCC—Truman Picks Miss Hennock, Lawyer in New York Firm, as Successor to Durr—First of Sex To Be Named—Appointee, a Liberal Democrat, Due for 7-Year Tenure—Aided O'Dwyer's Election 2527
The Evening Star, June 7, 1946, War Doctors' Worries Discussed at Meeting of Physicians' Forum 2553
The Sunday Star, January 20, 1946, Physicians' Forum Plans Open Meeting Saturday 2555
The Washington Post, January 20, 1946, Doctors To Hold First Conference on National Health 2555
The Washington Post, January 27, 1946, Health Plan Pressure Unit Is Organized 2556
The Washington Post, March 8, 1946, Health Plan to Cover Everyone in Nation Urged by Dr. Parran 2556
The Washington Post, May 25, 1948, President Nominates Woman To Serve as Member of FCC 2474
The Washington Post, May 27, 1948, Social Security Funds 2530
Parran, Thomas A., M. D., letter to, from Kenneth C. Crain, vice president, eastern editor, Hospital Management, New York, N. Y., in reply to Dr. Parran's letter 2622
Parran, Thomas, Surgeon General, memorandum from, to Leonard J. Calhoun, general counsel's office, Federal Security Agency, in re Wagner bill, S. 1161 2619
Partial list of members of two nongovernmental lobbying groups and of invited delegates to the National Health Assembly, Inc., May 1–4, 1948 2549
Steffen, Curt, M. D., F. I. C. S., letter of, addressed to Mrs. Shearon in re study of compulsory health insurance 2598
Steffen, Curt, M. D., F. I. C. S., report of, from Social Service Review, September 1947, Medical Care Under Compulsory Sickness Insurance in Germany 2599
St. Louis Medical Society publication, The Program Tuesday, Mar. 30, 1948, 8:30 p. m., excerpt from 2575
Williams, Dr. Vincent, editorial by, in Medical Society Weekly Bulletin of Jackson County, Mo., Editorially Speaking—Who Slants the News; Is "All Quiet on the Potomac"; or Do Leopards Change Their Spots? 2606

Smith, Hon. H. Alexander, a United States Senator from the State of New Jersey, insertions of—
Page
- American Medical Association, report of special committee on executive session of, for consideration of Rich report — 2718
- Anderson, Dewey, executive director, Public Affairs Institute, Washington, D. C., letter of, to Senator Smith, in re testimony of Mrs. Marjorie Shearon — 2720
- Bates, William, M. D., Philadelphia, Pa., letter of, addressed to Senator Smith, transmitting material in re Rich report — 2718
- Boas, Ernst P., M. D., New York, N. Y., letter of, to Senator Smith, transmitting copy of letter sent to newspapers in re testimony of Mrs. Marjorie Shearon — 2722
- Clark, Dean A., M. D., medical director, Health Insurance Plan of Greater New York, letter of, with enclosures, addressed to Senator Smith, in re healthi-nsurance plan — 2713
  - Rappleye, Dr. Willard C., chairman, board of directors, Health Insurance Plan of Greater New York, statement of, in re health insurance plan — 2715
  - New York State Journal of Medicine, July 15, 1947, excerpt from, by George P. Farrell, Standards for Approval by Medical Society of the State of New York of Voluntary Nonprofit Medical Care Plans in New York State — 2715
  - Watertown Daily Times, May 25, 1948, editorial from, Doctors and Progress — 2717
  - New York Herald Tribune, May 22, 1948, editorial from, A Step Backward — 2717
  - New York Times, May 21, 1948, editorial from, A Sound Health Plan — 2718
- Falk, I. S., Director, Bureau of Research and Statistics, Social Security Administration, letter of, to Senator Smith, transmitting statement on testimony of Mrs. Marjorie Shearon — 2723
- Moulton, Dr. Harold G., president, The Brookings Institution, letter of, to Senator Smith, in re Davis-Anderson review of Brookings report — 2701
- National Physicians Committee, insertions of—
  - Statement of, in answer to charges inserted in the record of the Subcommittee on Health by Hon. James E. Murray, Senator from Montana — 2701
  - Exhibit 1—Editorial to editors from Editor and Publisher, March 20, 1948, Socialized Medicine and Communist Purpose — 2706
  - Exhibit 2—Editorial to editors from Editor and Publisher, March 27, 1948, Political Medicine and Moral Deterioration — 2708
  - Exhibit 3—Editorial to editors from Editor and Publisher, April 3, 1948, Deceitful Manipulation of Draft Statistics — 2709
  - Exhibit 4—Editorial to editors from Editor and Publisher, April 17, 1948, Low Income Groups and Medical Service — 2710
  - Exhibit 5—Editorial to editors from Editor and Publisher, April 10, 1948, Anent Cash Awards for Cartoonists — 2712
- Pratt, John M., administrator, National Physicians Committee for the Extension of Medical Service, Chicago, Ill., letter from, addressed to Senator Smith, transmitting statement of committee in re its activities with respect to S. 545 and S. 1320 — 2701
- Statement for the record, submitted by, in re Senate committee print No. 5 — 2399

APPENDIX

Anderson, Mrs. Arthur Forrest, president, National Board of the Young Women's Christian Association, New York, N. Y., statement of — 2741
Anderson, Gust, secretary, Central Labor Council of Portland and Vicinity, letter of — 2742
Anderson, H. B., secretary, Citizens Medical Reference Bureau, Inc., New York, N. Y., statement of — 2743
Bowen, Dr. Sarah, medical director, Embudo Hospital, Embudo, N. Mex., statement of — 2747
Burnett, Newton I., secretary, Hamilton Trades and Labor Council, Hamilton, Ohio, letter of — 2749
Citizens' Committee to Extend Medical Care, Chicago, Ill., statement of — 2752

Page
Cohen, Harry, president, Baltimore Federation of Labor, letter of 2754
Consumers Union of United States, Inc., New York, N. Y., statement of ... 2755
Cornely, Paul B., M. D., Washington representative, National Medical Association, statement of ... 2756
Densford, Katherine J., R. N., president, American Nurses' Association, New York, N. Y., statement of ... 2757
Donnell, Hon. Forrest C., a United States Senator from the State of Missouri:
  Memorandum of, clarifying certain statements in re the publication and distribution of a chart prepared by Marjorie Shearon, Ph. D., entitled "Administration Plans for Nationalization of Medicine Emanating from the House of Falk" ... 2803
  Administration Plans for Nationalization of Medicine Emanating from the House of Falk, a chart prepared by Marjorie Shearon, Ph. D. ... faces .. 2804
Elliott, Taylor, secretary, Wood River Central Labor Union, Wood River, Ill., statement of ... 2758
Evans, Mrs. Josephine Anderson, National Nonpartisan Council of Alpha Kappa Alpha Sorority, Washington, D. C., statement of ... 2760
Howard, Dr. Joseph H., Bridgeport, Conn., statement of ... 2763
Jones, LeRoy, M. D., manager, New Mexico Cooperative Health Association, Old Albuquerque, N. Mex., letter and statement of ... 2771
Lull, George F., M. D., secretary and general manager, American Medical Association, Chicago, Ill., letter of ... 2776
Marr, J. T., executive secretary, Oregon State Federation of Labor, statement of ... 2777
Murphy, Emmett J., Washington, D. C., statement of ... 2778
Murray, Hon. James E., a United States Senator from the State of Montana, certain correspondence of—
  Letter addressed to Willard C. Rappleye, M. D., chairman, board of directors, Health Insurance Plan of Greater New York, New York, N. Y ... 2736
  Letter from Willard C. Rappleye, M. D ... 2736
  Letter from Melvin L. Dollar, executive director, Group Health Association, Inc., Washington, D. C ... 2739
  Letter from Fred V. Shadid, Community Hospital, Elk City, Okla ... 2740
National Organization for Public Health Nursing, statement of ... 2780
Nixon, Russ, Washington representative, United Electrical, Radio and Machine Workers of America (CIO), statement of ... 2783
Oxholm, Mrs. Theodore, chairman, Spokesmen for Children, Inc., New York, N. Y., statement of ... 2784
Raymond, Malcolm L., M. D., Johnstown, Pa., letter and statement of ... 2785
Richman, Leon H., Joint Committee on Social Security, Cleveland, Ohio, statement of ... 2789
Schutzer, Arthur, State executive secretary, American Labor Party, New York, N. Y., statement of ... 2792
See, Harry, national legislative representative, Brotherhood of Railroad Trainmen, Washington, D. C., statement of ... 2793
Smith, J. S., president, Virginia State Federation of Labor, statement of ... 2795
Stephenson, Faye, president, Congress of Women's Auxiliaries of the CIO, Cleveland, Ohio, letter of ... 2798
Todd, Dr. Arthur J., manager, Christian Science Committee on Publication, Washington, D. C., statement of ... 2798
Winston, Ellen, commissioner, the North Carolina State Board of Public Welfare, letter of ... 2801
Wise, Rabbi Stephen S., president, American Jewish Congress, New York, N. Y., letter of ... 2802

NATIONAL HEALTH PROGRAM

FRIDAY, JANUARY 30, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee hearing room, Capitol Building, Senator H. Alexander Smith (chairman of the subcommittee) presiding.

Present: Senators Smith (presiding), Donnell, and Murray.

Senator Smith. The committee will please come to order. Before we call the witness, Senator Donnell wishes to make a brief statement in regard to some of the testimony that we received yesterday.

Senator Donnell. Mr. Chairman, yesterday there was put in evidence WD–9 on this particular matter, in which the names of Sanders, Klem, or Louis Reed were contained, WD–9 reading: "What would your reaction be to following individuals for work on health insurance: Sanders, Klem, or Louis Reed? Do you have any other suggestions?" and Mr. Cohen, when we got to Louis Reed said, as I recall it, that Mr. Reed was—I don't recall his words just now, but to the effect that he was against, or tending to be against—something to that effect—compulsory health insurance. I don't recall his exact statement, but it was to the effect that Mr. Cohen felt that he had been against it, and I said in substance that I believed he was correct in that; that it had not occurred to me when I started to question about Mr. Reed that it was a man that I had previously met, and I said that I had a file and I would look it up, and I did look it up.

It is quite an informal file, I may say; I would like to state, however, what the gist of it is. My daybook indicates—it has an entry on November 19, 1947, "2 p. m. Mr. Reed," from which I judge that it was that date on which Mr. Reed came to my office. And I may say that Senator Smith and I had talked about securing—or rather, talked about Dr. Reed in connection with someone to be employed here by the committee in the capacity in which Mr. Sneed, by the way, is serving at this time. I do not believe I had met Mr. Reed before, but I said that I would like to talk to him. I think that Senator Smith or Senator Taft, I don't recall which it was, had made some mention to me that in their understanding Mr. Reed, although at one time strongly for compulsory health insurance, had changed his view on it, or something to that effect. In looking over the notes here that I took, which are penciled notes, during this conference, I do not find any reference to that subject. I will try and analyze these notes as best I can. Anybody who wants to do so may see them.

I have got down here:

Research staff member Committee on Costs of Medical Care, Dr. Ray Lyman Wilbur, chairman.

I believe that means that Mr. Reed was employed by that committee on the research staff. Then he says that Mr. Falk was in charge of the research staff:

Wrote 4 of 27 medical research reports:

I think that means that Mr. Reed had written 4 of 27 medical research reports:

1. Healing Cults.
2. Midwives, Chiropodists, and Optometrists.
3. Medical Service of Homestake Mining Co.
4. Ability to Pay for Medical Care.

Instructor in economics, New York University.
Professor of economics, University of Texas, 2 years.
August 1935, Bureau of Labor Statistics (price indices).
April 1936, Social Security Board, Bureau of Research and Statistics. Dr. Falk not yet there.

I think that means that Mr. Reed came with that Bureau before Dr. Falk came with it.

With Bureau until December, 1939. Became Assistant Chief responsible to Dr. Falk.

Dr. Shearon came with us in 1937 or 1938. She knew of Mr. Reed's work with Dr. Falk. Mr. Reed helped draw up S. 1620. 1937 or 1938 published Health Insurance, The Next Step in Social Security. He is strong for compulsory health insurance, not national but with Federal aid to States. It might be confined at least at the start to low-income groups. Probably advocated therein that it might be extended to everyone.

That is sort of a synopsis that I took down of what I understood Mr. Reed to say about that work, his recollection of it.

Transferred to Public Health Service (Dr. Parran then its head). Mr. Reed was in Division of Public Health Methods, of which George St. J. Perrott was chief.

Medical care for public relief assistance recipients.

Study of Auburn, N. Y.; Westchester County, N. Y., and Yates County, N. Y., Virginia and West Virginia.

March 1942, detailed on loan to War Production Board, section on health supplies of office of civilian supplies.

1943, back to Public Health Service.

Thinks wrote first specification for Hospital Construction Act.

Reed debate between: (*a*) Van Steenwyck, head of Philadelphia Blue Cross, (*b*) Altmeyer (Arthur). Advocated compulsory health insurance.

I think that means Altmeyer advocated it.

Mr. Reed thought of United States Government assisting the Blue Cross, C. Rufus Rorem, who had become leader of Blue Cross movement. He had thought of Public Health Service making a survey of Blue Cross plans. It was entered on Michigan et al. The Field Service occupied a year. The survey was for me an eye opener.

Became impressed with complexities in prepayment plans.

Nonunderstanding attitude as Reed wrote report.

That is somebody that didn't seem to appreciate his attitude.

Finally some change of opinion favorable to Mr. Reed's views.

Then on the back here:

Pages 145, 232. Bachman of Brookings.

At that time Mr. Reed left with me a book that he had written entitled "Blue Cross Medical Service Plans," which I later looked into, and I know that I was impressed with one or two things here in that book, and I have noted them. Page 145 was the Murray-Dingell bill, and other proposals for compulsory health insurance.

> Served to spur congressional action for 1943 on. American Medical Association acted in many State and local medical associations. Establishment of Blue Cross plan, also perhaps development of the movement.

Then some statements over here on page 323:

> In short, the public needs complete health service on a prepayment basis, and the plans will be more useful if they provide for service.

Then he left two or three articles here which I have. On one of them here I observe a little note on the side, something that I wrote:

> From this appraisal it is apparent that the plans by themselves do not have the potentialities which achieve the ultimate object of bringing adequate comprehensive health services to the whole population, but it is also conceivable that with a high degree of governmental cooperation and assistance, plans might be able to achieve the goal in mind.

These are from volume 68, No. 2, February 1947. That is from Modern Hospital. Then another sheet here from Modern Hospital of the same month, and then this other document here is "Convention Digest, Modern Hospital, published October 1946."

I do not recall having asked Mr. Reed how he himself felt on compulsory health insurance. I don't think I asked him that question. I was going over his qualifications, and I have indicated here what my file shows. My recollection is that I told Senator Smith that I would like to speak to Dr. Shearon about this gentleman; that I had stated in response to his inquiry that Dr. Shearon knew Mr. Reed's work, and Dr. Shearon gave me certain of her views in regard to him. I have a note here in the course of which is "decided bias in favor of compulsory insurance." Then further over here "bias in favor of WMD bill." Then she pointed out that anybody is bound to take a position on that matter one way or the other, and that a person from the Federal Government, someone like Reed, as opposed to someone like herself, and I think she indicated that the contrast there was that she would be decidely opposed to it.

I don't remember Mr. Reed himself stating how he felt about it, but I did have this indication from, I think it was either Senator Smith or Senator Taft, maybe both of them—I am not sure—that their understanding was that he at one time had been for compulsory insurance and later on changed from that position. I know that in looking over these articles I became of the general impression here that Mr. Reed was, at least to some extent, in favor of the view that Blue Cross plans would not solve the problem, and that they should be supplemented in some way, and he thought about governmental assistance to the Blue Cross.

That is as nearly as I can give the substance of my file and my recollection in regard to the matter.

Senator SMITH. I think it is a very fair statement, Senator.

Senator DONNELL. I might say that I have not given all that Dr. Shearon told me here. I don't know that that is necessary, because it is of her impressions about him, and, after all, what is important is what Mr. Reed himself thought, rather than what Dr. Shearon thought about him—at least for the purposes of this meeting here this morning.

I wanted to state this in the record, so that we would have fully what my knowledge was.

Senator **Smith.** I appreciate the statement, Senator Donnell. It is a very fair statement. As a matter of fact, you have talked with Mr. Reed, and do not wish to leave the impression that you had not seen him or talked to him and did not know his record.

Senator **Donnell.** I said yesterday I did not recognize, when the name "Louis Reed" was mentioned, that it was the gentleman whom I had met, but when both Senator Smith and Dr. Shearon indicated to me that he was the same gentleman that had previously come to my notice I thought it was advisable and proper that I make this statement.

Senator **Smith.** It brings out very clearly your connection with the matter, Senator Donnell, and I appreciate your statement, inasmuch as it is in Mr. Reed's behalf to try to make clear what you understand his position in the matter was.

Are we ready to proceed?

Senator **Murray.** Mr. Chairman, before today's proceedings begin I would like to submit four documents and ask that they be included in the record of the hearings.

The first is a copy of the statement made by the Chicago Institute of Medicine in awarding a fellowship to Albert D. Lasker. The Senators will remember that Mr. Lasker testified here in favor of S. 1320, the National Health Insurance Act. That testimony was given in his capacity as a recognized leader in the world of American business. I believe the record should also show his relationship to the medical profession. As the award puts it:

> In recognition of the rare qualities of head and heart that have inspired him to become so valued an ally of the medical profession in advancing its scientific ideals, the Institute of Medicine, of Chicago, has chosen him for citizen fellowship and is honored by his acceptance.

The second is an article entitled "Public Health Insurance in the United States," which has been reprinted from the October 1947 issue of the American Catholic Sociological Review, Loyola University, Chicago, Ill. The article will be of interest insofar as it clearly sets forth the Catholic thinking with regard to the principles underlying the questions of social security in general and health insurance in particular.

Third, an article entitled, "Health Services in New Zealand." We already have in the record many references to the New Zealand program, and I understand that Dr. Shearon is submitting to us a pamphlet of her own on the subject. Most of the materials heretofore presented have been prepared by proponents of one point of view or another. Inasmuch as this particular study was prepared by Prof. Dean McHenry of the University of California, at Los Angeles, together with Dr. Hugh MacLean, Fellow of the American College of Surgeons, on an altogether objective basis, I believe the Senators will find it most informative.

The fourth is a letter which appeared in the Washington Star on January 15, signed by Dr. Thomas Mattingly, M. D., who sets forth some pertinent criticisms of S. 545. The fact that Dr. Mattingly cannot be considered a socializer of medicine will become apparent when I point out that he was one of the gentlemen indicted when the Government brought its successful suit against the AMA for violating the antitrust laws. Dr. Mattingly, I hasten to add, was not found personally responsible for his society's actions. I submit these documents for the record.

Senator SMITH. Without objection, they will be received. I am glad to say to Senator Murray that the contributions of Mr. Lasker have been called to my attention by some personal friends, and I am going to have the pleasure of seeing him this coming week.

(The material submitted by Senator Murray follows:)

INSTITUTE OF MEDICINE AWARD OF CITIZEN FELLOWSHIP TO ALBERT DAVIS LASKER

A man of distinguished ability in the business world, a man of imagination and vision, with keen interest in his fellow men and an urge to improve their lot. In the field of education he has been an outstanding benefactor, in recognition of which he was elected a trustee of the University of Chicago. During a long career he has been generous in support of hospitals and charitable institutions. For many years he has been impressed with the importance of research in advancing the understanding of the processes of disease, and in furthering the progress of medicine in its treatment. Twenty years ago he gave liberally to cancer research. Subsequently, with Mrs. Lasker, he established at the University of Chicago the Lasker Foundation for the Investigation of Degenerative Diseases. In recognition of the rare qualities of head and heart that have inspired him to become so valued an ally of the medical profession in advancing its scientific ideals, the Institute of Medicine of Chicago has chosen him for citizen fellowship and is honored by his acceptance.

R. T. WOODGATT, *President.*
GEO H. COLEMAN, *Secretary.*
Presented by JOSEPH A. CAPPS.

DECEMBER 3, 1941.

[Reprinted from the October 1947 issue of the American Catholic Sociological Review, Loyola University, Chicago 11, Ill.]

PUBLIC HEALTH INSURANCE IN THE UNITED STATES

EDWARD A. MARCINIAK

This is an age of medical wonders. The discovery of penicillin and sulfa drugs and the development of modern surgery have lessened tremendously the physical risks of illness and disease. The effective use of public health and sanitation measures in recent years has cut the toll of diphtheria, typhoid, and tuberculosis beyond wildest expectations In 1850 the life expectancy of a baby boy was 40 years. In 1900 it was 46; by 1930 it was 59. Today it is over 65.

The combined efforts of doctor, dentist, research scientist, laboratory technician, nurse, Government, and hospital have made America one of the healthiest Nations in the world. American people now have less reason to fear the "Five D's"—defect, disability, disease, disorder, and deficiency.

But this is not the whole story.[1] There are at present an estimated 25 million Americans who have some chronic illness or physical impairment. While millions of Americans enjoy good health and have the money to pay for good medical care when it is needed, millions of other Americans are the victims of avoidable hardships because they cannot afford decent medical care. A great many American families are daily faced with the bewildering reality of an illness which they are not prepared to meet financially. As a result, millions of Americans, especially those who belong to the lower income groups, are trapped in a vicious circle of recurring sickness and diminishing income. It is a well-known fact that the more often people (in low income brackets) are sick, the less money they earn. The less they earn, the more often does sickness strike these people. Good food, adequate shelter and clothing, and periodic medical examinations are among the most potent protections against illness. And it is these things that the poor and less well-to-do families are unable to procure in sufficient quantity and quality.

---

[1] For an uneven but fairly comprehensive picture on the state of the Nation's health see National Health Program, hearings before the Committee on Education and Labor, U. S. Senate, 79th Cong., sec. sess., on S. 1606. Hearings are in five parts and total 3,086 pages. See especially the testimony of Father Raymond A. McGowan, pp. 1667–88; Father Alphonse Schwitalla, S. J., pp. 1787–1818; and Msgr. John O'Grady, pp. 1819–45. For statistical summary of health facts, see Gerhard Hirshfield and Carl W. Strow, Comparative Health Factors Among the States, American Sociological Review, February 1946, 11 (1): 42–52.

See also the recently published Compulsory Health Insurance by Elizabeth W. Wilson, New York: National Industrial Conference Board, 1947.

This article is a study of the economic and social hazards of ill health and accidents and of the ways in which health insurance can lessen these hazards. We shall observe the facts about the distribution of medical care in the United States, judge the situation in the light of Catholic social principles, and discuss a program of action. This article is about medical economics and social principles. It is not a medical treatise.

I. THE PROBLEM

The health facts revealed by the U. S. Selective Service System during World War II were not only startling, they were also disheartening. Of the first 14,000,000 young men (all in the prime of life) examined: only 2 million met the Army's high medical standards; another six-and-a-half million were found to have various defects, but were accepted for military service; of these one million left the Army as medically discharged when defects were discovered or developed after induction. Approximately 2¼ million were remediable 4-F's (about 1½ million were rehabilitated under the Army's medical plan and accepted for military service); 3½ million were found to be hopelessly unfit.

On the basis of these facts, United States Senate Subcommittee on Wartime Health and Education estimated that 40 percent (8 to 9 million) were unfit for military service.[2] Commenting upon these results the Social Security Board said in November 1945:

"While some requisites for military service do not necessarily apply to peacetime pursuits, the majority of the conditions which cause rejection unquestionably handicap these men in civilian life. Experts believe that from a third to a half of the defects and diseases of the men rejected could have been prevented with adequate medical care. A considerable proportion of the defects could be remedied with proper medical care."

The facts also reveal that inadequate medical care is both a cause and effect of low income. Negroes, Mexicans, rural tenant farmers, southern sharecroppers, and urban slum-dwellers all belong to groups where the quantity and quality of medical care is usually inadequate. People in the bottom income groups face the worst dangers of bad health. Medical studies show that people in low-income groups are sick more frequently and for longer intervals than people in top-income levels. Thus, ill health hits hardest the group least able to bear the financial costs of good medical care. In a poll conducted by the National Opinion Research Center in 1944, 31 percent of the people interviewed said that they had at one time or another put off going to the doctor because of the cost.

Furthermore, in the boom year of 1929 the Committee on the Costs of Medical Care found that American families with annual incomes of less than $2,000 were receiving insufficient medical aid. Here are the figures:

Kind of care	Amount received	Additional care needed
	Percent of need	*Percent*
Hospital	67	33
Medical	36	64
Dental	18	82
Health examination	9	91

This same committee reported that about 38 percent of the United States population was receiving inadequate or no medical care. The National Health Survey made in 1935–36 found that about 2 million of the most serious ilnesses each year were not given any medical attention. The seven States with the lowest per capita incomes average less than two available hospital beds for every 1,000 people. (The generally accepted standard is 4.5 beds for every 1,000 persons.) In addition, 40 percent of the Nation's 3,000 counties, totalling 15,000,000 people, do not have a recognized general hospital.

---

[2] Even making allowances for the very high medical standards set by the Selective Service System and for some minor duplications in rejection, the rejection rate is high enough to warrant serious public concern.

Studies made of relief clients have indicated that, except for the depression years, illness is the greatest single reason forcing families to seek public assistance or charitable aid. In a special analysis of New York's "Hundred Neediest Cases" in 1944–45 it was found that 80 percent of the families were poverty-stricken because of illness or the heavy burden of medical costs. According to the American Association of Small Loan Companies the greatest single cause of people going into debt is the need of paying a hospital, medical, or dental bill. Other studies made in Illinois and California reveal that the greatest single explanation for the redemption of Government war bonds during the last year of World War II was the cost of ill health. The economic problem of bad health is also indicated by the fact that prior to World War II there were 39,000 physicians in the United States who were earning less than $2,000 a year.

Dr. Howard Rusk, chairman of the Department of Rehabilitation and Physical Medicine of the New York University College of Medicine, estimated in 1947 that "about 97,000,000 people in the United States need financial help to meet the cost of serious illness. This averages two persons out of three."

The American Medical Association has estimated that on a fee-for-service basis, families with incomes of less than $3,000 cannot meet the expenses of a serious illness. In 1942, 70 percent of American families were earning an annual income less than that amount. Even in 1946, a very prosperous year in the history of the United States, half the family spending units earned less than $2,340 and would have been unable to meet such a crisis satisfactorily. Even making allowance for the fact that some of these "family units" have one, two, or three members, the figures reflect an appalling inability on the part of many people to pay the price of good health care. Other studies have shown that families with incomes over $10,000 average twice as many calls per person each year as those in families with average annual incomes less than $1,200. These and other studies show that the physical need for medical care has always been greater than the effective demand for it. A man may need medical attention but can only effectively demand such care when he can afford it.

II. PAYING MEDICAL BILLS

The costs of medical care in the United States are being paid for by four systems: (1) the pay-as-you-go plan, (2) voluntary health insurance, (3) public health insurance, (4) State medicine.

Pay-as-you-go.—Most Americans now pay their medical and hospital bills on a fee-for-service basis. When illness or accident occurs, the medical costs, if the money is available, are paid for on the spot. Here the medical payment is made directly by the patient to the doctor or to some clinic organized and operated jointly by a group of physicians. This has been a traditional method of meeting medical bills, and the one with which Americans are most familiar.

Voluntary health insurance.—This method of payment operates on the principle of insurance. Payment is made in advance into a fund which is then used to pay the costs of medical care. Health insurance, like fire insurance, takes advantage of the law of averages so as to spread the risks. Under fire insurance all pay premiums, but only the one who has the fire benefits directly from the insurance. Under a voluntary health insurance plan, the sick and well pay into an insurance fund, and the sick benefit directly. Voluntary insurance pools the risks and spreads the costs.

In the United States about 25 percent of its 140 million people are covered by one of the various forms of voluntary health insurance. Less than 4 percent are completely covered by medical care insurance, i. e., hospital and doctor's service in home, hospital, and office. (Ordinarily this "complete" care does not include the expenses of drug supplies, dental care, home nursing, and expensive specialized care.)

Voluntary insurance plans are of many kinds. Blue Cross plans, for small monthly payments, provide hospital care and certain other benefits. These plans, sponsored by the American Hospital Association, cover about 27 million people.[3] For yearly fees, which average about $15 a year for an individual and $40 for a family, Blue Cross subscribers can obtain up to 30 days of semiprivate hospital care in any member hospital, the use of an operating room, and certain other benefits (including a 50 percent discount on hospital care lasting more than 30 days).

Industrial plans are financed through pay-roll deductions, joint labor-management contributions, or by management alone, and provide medical care and/or hospital services for employees of a particular industry.[4] Similar plans are also sponsored by labor unions, e. g., the International Ladies Garment Workers Union. Commercial medical insurance plans which are promoted by State medical societies provide a variety of medical services but very frequently exclude important medical care like maternity benefits and certain surgical care.

---

[3] The great proportion of those covered is urban.

In addition to these there are cooperative medical and hospital groups, like the Group Health Association of Washington, D. C., which for a monthly premium ($2.50 for an adult, $10.25 for a family of five) provides wide medical care; plans operated with special group clinics, such as the Ross-Loos Clinic in Southern California which furnishes medical service for a prepaid monthly fee; and medical care plans sponsored by the Farm Security Administration.

There were seven cooperative hospitals and forty cooperative health associations in the United States in June 1947. One of the newer, nonprofit health insurance plans is the Health Insurance Plan for Greater New York. For a family cost of about $40 a year it provides

General medical, specialist, surgical and maternity care at the home, doctor's office, group center, or the hospital.
Diagnostic and laboratory services.
Physical therapy, X-ray, and other special treatments.
Periodic health examinations, and immunizations.
Eye examinations.
Visiting nursing service at home, psychiatric advice, and ambulance service from home to hospital.

There are no waiting periods or age limitations. For a slight charge maternity benefits may be immediately secured. It is a group plan with employees becoming eligible if 75 percent join and the employer is willing to match the premiums paid by the employees. All residents of Greater New York earning under $5,000 a year, their wives and children under 18, are eligible. Members may select a family doctor from a group of participating doctors in their area. Under such a plan, plus payment to a Blue Cross plan, a worker can get complete medical and hospital coverage for less than $100 a year (about $125 a year if the employer's financial contribution to the Health Insurance Plan is included).[4a]

Public health insurance.—This method of payment also operates on the insurance principle. Under this arrangement medical and hospital expenses would be paid from a government-created insurance fund supported by employer-employee contributions through pay-roll deductions. Under the public-health insurance program discussed in this article, patients and doctors would choose each other. The doctor would provide services as he always has; patients would select hospitals and hospitals would accept patients as they now do under group hospitalization plans, the major difference being that the expenses under a public insurance program are paid out of a public fund into which all wage earners within a certain income group would be required to contribute.

Such a form of public health insurance is not foreign to the United States. Back in 1798 the United States pioneered in this field with a hospital care program for merchant seamen that was financed by pay-roll deductions and administered by the U. S. Public Health Service. This health insurance program was operated until 1870 when the hospital program was financed out of general tax funds as a Federal program.

Health insurance is not "relief," "charity," or public assistance. It gives people an opportunity to get medical care as their right because they have been making payments for such service. "Once they learn what health insurance means, normal people much prefer it to public assistance, to public clinics, to needs tests, to the embarrassment of asking for credit or outright charity, or to any of the other devices which have become traditional because the cost of health was beyond the means of the average man."[5]

---

[4] Henry Kaiser's famous medical care program on the Pacific Coast is a good example of an industrial plan. It protects 25,000 workers, most of whom are employees in various Kaiser industries. In the San Francisco area each worker pays $2.60 a month for himself, $1.85 for his wife, and 80 cents for his children, regardless of number. Thus a whole family is insured for $5.25 a month.

For this monthly premium, the worker may receive: (a) Up to 111 days of hospital care for illness or accident incurred while a member; (b) all medical and nursing services, drugs, X-rays, and laboratory tests; (c) full medical treatment at home or in doctor's office, but with a $2 charge for the doctor's first visit in any illness.

The wife and children are entitled to: (a) 30-days hospital care for each sickness; (b) medical care at $1 a visit to doctor's office and $2 for house calls; (c) while in hospital, free drugs and medicine and X-ray and physical therapy treatments at half-price.

The doctors are employed on a salary basis. Under the original plan, the policy making was done by the Kaiser Co., but under new proposals the unions would have full partnership in administration and policy.

[4a] See Neva R. Deardorff, The Health Insurance Plan of Greater New York Begins Service, Social Service Review, 21: 157–70, June 1947.

Forty-seven States now have partial systems of compulsory health insurance as applied to occupational accidents and diseases. Workmen's compensation legislation, authorizing insurance protection for employees, provides better medical care for the victims of industrial accidents and better compensation for hospital and physician. A broad plan of public health insurance is all-inclusive because it would protect employees and their families against the expenses of nonoccupational accidents and ailments.

Thirty-two countries, including England, Ireland, Brazil, France, and Spain, operate national systems of compulsory health insurance.

An indirect approach to the problem of health costs is to be found in Rhode Island. Since 1942 Rhode Island has had a State-operated "disability insurance" program. Operating on a basis similar to unemployment compensation, cash benefits are paid to employees who are ill. The plan covers the State's 350,000 workers who earn more than $100 a year. Cash benefits from $6.75 to $18 a week—depending upon earnings—are paid for a maximum of 20 weeks a year. While primarily designed to compensate a worker for the wages lost while sick, it indirectly helps pay medical bills by maintaining the workers' income during a period of illness. To put the plan into operation no pay-roll deductions were necessary. A portion of the 1½ percent paid for unemployment insurance by employees on their earnings up to $3,000 was allocated to disability insurance.

State medicine.—Where the Government hires the doctors, builds and staffs the hospitals, etc., State medicine exists. In the United States it is a common practice. Examples of State medicine can be found in the Army and Navy Medical Corps, in the U. S. Public Health Service, in the Veterans' Administration, in municipal, county, and State hospitals, in mental institutions, in public clinics, etc.

Socialized medicine.—This is a sysem whereby all of the Nation's medical and hospital services and medical associations are operated by the Government, displacing all private and group medical services. All doctors and dentists, hospital staffs, would be on the Government pay roll. Only Soviet Russia operates under a system of socialized medicine. It is, actually, a government monopoly of medicine.

Socialized medicine, then, should not be confused with public health insurance which supposes that private medical practitioners and the private hospitals will dispense the services. Under socialized medicine the fee system would be abolished. Under a health insurance system, the fee system remains, and doctors and hospitals are reimbursed for their services from group or public insurance funds.

People should not confuse the issues by labeling public health insurance as socialized medicine. Public health insurance is not socialized medicine; it is a method of paying medical and hospital costs in advance. One can be in favor of public health insurance and at the same time be vigorously opposed to socialized medicine. Those persons who label health insurance as Communistic are not only misrepresenting the facts but are actually playing into the hands of the Communists. For the Communists are being given credit for a social program which has been operating successfully in many countries all over the world and which has been supported by Catholics in Europe and the United States. Men may honestly be against public health insurance for the United States, but it is dishonest to describe a privately operated health system supported by public insurance as "socialized medicine."

III. CATHOLIC SOCIAL TEACHING

This is the place to discuss Catholic social teachings as applied to health, insurance, group action, and governmental intervention.

Good health is not an indispensable good for the Christian. But bad health may, under some circumstances, become an obstacle to reaching Heaven and seeing God face-to-face. It is obvious that sickness can be a blessing—both to the sick and to those whose privilege it is to serve the sick in the name of Christ. Even when sickness results from inadequate income in an economic system which distributes wealth and income unjustly, such illness can and should be turned to spiritual and supernatural good. For the Church encourages Christians to unite their sufferings and hardships with Christ's supreme offering at the Holy Sacrifice of the Mass. Saying all this, however, cannot reasonably be construed as an argument against changing the economic system and distributing justly the wealth. Part of this wealth is medical care.

---

[5] William J. Gibbons, S. J., "Health Insurance," America, June 8, 1946, 75 (10) :192–3.

The Catholic Church has never regarded it virtuous to keep people sick. Indeed, the Church, arguing from both reason and faith has never regarded it virtuous for people to keep themselves sick. Good health has been regarded as an important part of a good life, to be guarded with reasonable caution, and to be prayed for, as the Church does repeatedly in her Liturgy, as the foundation of a supernatural life and as a normal means for making the service of God and of men more complete and self-sacrificing.

The Catholic Church's attitude toward the sick is best indicated by her practice. For almost 2,000 years, the Church has founded and encouraged hospitals, institutions, and charitable agencies to aid the sick, infirm, lame, and blind. Religious communities dedicate their lives to serve the sick in the name of Christ. In the Catholic's eyes comforting the afflicted and visiting the sick are works of mercy—God-sent opportunities to love the children of God.

The dignity of man as a child of God is the source of the Church's anxiety for his well-being and a key point of Catholic social teaching. Man is not just an animal with a physical nature. Because of his soul, man has been created to God's image and likeness. In addition, man has been redeemed by Jesus Christ, adopted as a child of God, and called to membership in Christ's Mystical Body.

But it is a mistake to believe that man's natural and supernatural dignity relieves him of a normal concern for his physical welfare. This double dignity only makes more important man's right and duty in this regard: *The right* to be secure against those dangers to good health which result from society's failure to solve its economic and social problems; *the duty* to take care of himself and those dependent upon him. Each man is expected to do his utmost to satisfy his personal needs. A good government and a decent community will encourage him to provide protection for his own health and his family's.

With a little care and common sense, with a few essential facts about good health, with an adequate income and a thrifty budget, a man is usually able to face without fear the risks of illness and accident—under the providence of God. But where men do not enjoy the blessings of a decent income, the spectre of ill health casts a shadow over a man and his family. For a serious illness or accident may jeopardize his security and mortgage his future with debt.

One strong moral inducement for men to assume personal responsibility for their physical welfare is a fully adequate family wage. Pope Pius XI said that "social justice cannot be said to have been satisfied as long as workingmen are denied a wage which will enable them to secure proper sustenance for themselves and their families; as long as they are denied the opportunity of acquiring a modest fortune and forestalling the plague of universal pauperism; as long as they cannot make suitable provision through public or private insurance for old age, for periods of illness, and unemployment."

The first line of defense, then, against the *economic* risks of sickness is sufficient property and a living, savings wage for all adult workers. This is the best way to meet the bills of a doctor, hospital, nurse, and pharmacist. But if men don't own property (their land, their home, their place of employment), if men do not earn a decent wage, they cannot meet these bills. Families with incomes less than $2,000 a year are certainly not prepared, financially, to meet the hazard of serious illness and in many cases to obtain ordinary medical treatment.

Any step taken to raise the real income of American workers is a step toward providing better health opportunities. The American bishops in 1939 asked that: "Workingmen should be made secure against unemployment, sickness, accident, old age, and death. The first line of defense against these hazards should be the possession of sufficient private property to provide reasonable security. Industry therefore should provide not merely a living wage for the moment but also a saving wage for the future against sickness, old age, death and unemployment. Individual industries alone, however, cannot in each single case achieve this objective without invoking the principle of social insurance."

Labor unions, the annual wage, minimum wage laws, rural cooperatives, profit sharing, group insurance, etc., are some of the many ways of lifting the poor man's real income. And any boost in real income ordinarily means better health protection.

To be realistic, it must be admitted that it will be many years before every family in the United States will have an income large enough to provide for the necessities and ordinary comforts of civilized living. What then is to be done about the financial risks of good health? What have men been doing during the last decade about this problem? How can they aid their fellowmen economically in problems of sickness and accident?

Many Americans have banded together in Blue Cross hospital plans, have formed cooperative medical centers, shared in industrial and union sponsored health programs, or have taken out medical insurance. By these plans they have attempted to balance the cost of illness with the size of their pay check. By this cooperation men have recognized their right and duty to work together for mutual aid.

Such personal and social responsibility should receive the encouragment and endorsement of all those who profess a belief in the dignity of the human person. To form such mutual-help organizations is as natural for man as it is for the bird to fly. The Bible (Eccles. IV, 9) says that "It is better that two should be together than one, for they have the advantage of their society." By cooperating with each other men are able to provide goods and services which they could not furnish alone. Every effort should be made, including the assistance of the government, to promote and develop such cooperative, joint organizations for better health. As medicine is designed to heal sick men, so joint economic activities, like health insurance, are designed to heal a sick society. The task of Christians in this matter was made clear by Pius XII:

"Do not let die in your midst and fade away the insistent call of the social encyclicals, that voice which indicated to the faithful in the supernatural regeneration of mankind to cooperate in the arrangement of society and especially of economic life, exhorting to action those who share in this life, no less than the state itself. Is not this the sacred duty for every Christian?"

What is the government's job in providing for man's temporal needs? Has it no part to play in the papal plan for social reconstruction? Specifically, is people's health a matter for governmental action? How do we distinguish the part to be played by the individual, the group, and the government? Do all three have equal responsibilities? Or is there some principle of subsidiarity which should be applied?

To these questions Pope Leo XIII and Pope Pius XI have given unequivocal answers. Leo XIII said in his famous encyclical "On the Condition of Labor" that: "When there is a question of protecting the rights of individuals, the poor and helpless have a claim to special consideration—those who are badly off have no resources of their own to fall back upon, and must chiefly rely upon the assistance of the state. . . . And it is for this reason that wage earners, who are, undoubtedly, among the weak and needy, should be especially cared for, and protected by the state."

Pope Pius XI has said that: "It is the duty of rulers to protect the community and its various elements, and in protecting the rights of individuals they must have special regard for the infirm and needy."

These principles provide the key to an understanding of the papal teaching on the function of government. Governmental action is justified when individuals and voluntary organizations (labor unions, group health associations, cooperatives) fail to do the job. The intervention of the state, then, depends upon the ability of individuals and smaller groups to provide these necessary goods and services. If they cannot, and the public good suffers, the government not only may intervene, it must step in to protect the common good. Pope Leo XIII's words are a classic statement of the respective roles of individuals, voluntary organizations, and government in social and economic life: "Whenever the general interest or any particular class suffers, or is threatened with, evils which can in no other way be met, the public authority must step in to meet them."

These principles for the guidance of governments reject a political philosophy which says: "That government governs best which governs least." Instead the Christian principle states: That government governs best which rules for the common good and protects the interests of needy groups—especially the poor, sick, and helpless.

Furthermore, this principle provides that governmental actions should be a supplement to existing individual and group efforts to meet a social problem. "It is the duty of public authority," says Pope Pius XI, "to supply for the insufficient forces of individual effort." When the government finds itself morally obliged to provide aid for the ill and injured, it must not destroy or take over the good work now being accomplished by private hospitals, cooperative medical plans, industrial hospitalization systems, religious communities, etc. If the government is really the servant of the people, it will serve and supplement, not dominate or supplant individual and group effort. "The government," Pope Leo XIII said, "must not absorb the individual or the family; both should be allowed free and untrammelled action so far as is consistent with the common good and the interest of others." It will encourage and promote voluntary organizations; and it will provide direct service where individuals and associations are inadequate for the task. During the days of the great depression of the 1930's the relief agencies did not supplant private charitable aid, but rather supplemented it.

In upholding this principle of legislation, the Christian is a champion of both freedom and security. *Freedom* for individuals and groups to provide for their own needs—if they are able to do so. *Security* for individuals and groups who, unable to help themselves, are helped by the government. Pope Pius XI has said workers should be freed "from the insecurity which is the lot of the proletariat."

Pope Pius XI has made it clear that where necessary the government has a perfect right to set up an insurance system to aid the sick and needy. "Social justice," Pius XI said, "cannot be said to have been satisfied so long as workingmen are denied a salary that will enable them to secure proper sustenance for themselves and their families . . . as long as they cannot make suitable provision through public or private insurance for old age, for periods of illness, and for unemployment."

In quoting Pope Pius XI it is not the author's intention to say that the Pope is advocating a public health insurance program for the United States. It is, however, the author's intention to explain that Christian social teaching approves of public and private health insurance in principle where conditions outlined above are fulfilled.[6a] Whether public health insurance should be adopted in the United States is a matter of practical judgment that depends upon local conditions. On this point Catholics may come to different conclusions. For involved in this judgment is an estimate of the present adequacy and the future ability of voluntary organizations to handle the United States' health problem. However, those individuals, and especially Catholics, who oppose a national health insurance program for the United States should make it clear that they are not denying the government the right to legislate on health insurance. Furthermore, the fact that some particular health program [6b] which is proposed may have real or imagined weaknesses does not deprive the government of its right to intervene in such matters. Christian social teaching not only gives the state the *right* to enact a national health insurance law but also imposes a *duty*, under certain conditions, to set up a universal health insurance program.

What are these conditions? Following Pope Leo XIII's guiding principle for state intervention, it may be said that public health insurance becomes a necessity

(1) when there is a real need among the nation's families for good medical care;

(2) when the common good or the physical welfare of these people is jeopardized by their lack of medical care;

(3) when existing agencies and organizations are unable to cope with the problem;

(4) when government action is the only way of protecting these families against the risks of sickness and providing for the common good.

Some attempts have been made by Catholic sociologists to apply these principles to the concrete conditions in the United States. Monsignor John Augustine Ryan said in 1943:

"The millions of our citizens who are suffering from unnecessary sickness or from insufficient medical attention, can obtain adequate care only through a system of public health insurance But the system should allow full freedom for group health projects and cooperative hospitalization. When organized groups can guarantee to their members at least as large benefits as those offered by the public system, they should be authorized to operate autonomously. This arrangement would exemplify that fundamental principle of democracy which dictates that the state should never do anything for the citizens which they can do as well for themselves."

[6a] European Catholics have taken a similar position. Father Lewis Watt, S. J., says: "That under appropriate circumstances should be 'social' (i. e., compulsory) insurance has been steadily maintained by the Catholic Social Movement on the Continent. To say nothing of the support given social insurance last century in Germany, Belgium, Holland, and Luxembourg, the representatives and the influential Catholic organizations L'Action Populaire gave strong support to the introduction of social insurance [including sickness insurance] into France in 1930, and the Bishop of Autun wrote: 'Certain newspapers urge organized resistance to the application of the law on social insurance. The clergy and Catholics must not take part in this maneuver against a law which, in spite of inevitable imperfections, realizes one of the wishes of Leo XIII in his encyclical *Rerum Novarum*]"—Lewis Watt, S. J., *A Catholic View of the Beveridge Plan.* Oxford: Catholic Social Guild, 1943. Pp. 17–18.

[6b] See, for example, the discussion which has centered around the health insurance legislation introduced by Senators Robert Wagner and James Murray and Congressman John Dingell.

Back in 1919 the "Bishops' Program of Social Reconstruction" recommended that: "Until the level of legal minimum wages is reached, the worker stands in need of the device of insurance. The state should make comprehensive provision for insurance against illness, invalidity, unemployment, and old age."

Commenting upon this statement of the Bishops, Cardinal Edward Mooney of Detroit (then Archbishop Edward Mooney, chairman of the administrative board of the National Catholic Welfare Conference) said in 1939:

"The social insurance provided in the Social Security Act is by no means perfect. To say nothing of other defects, it fails to provide for workers' insurance against sickness."

In 1945 Bishop Francis J. Haas of Grand Rapids, Michigan, speaking in Chicago at a Labor Day Mass in Holy Name Cathedral, said:

"Now and without delay, Congress should . . . broaden the Social Security Act to include health insurance."

On the same day, speaking in his own Cathedral, Bishop Michael Ready of Columbus said that one of the "social objectives worth working for in our national economy is comprehensive social security—giving protections against unemployment, disability, old age, sickness, and dependence. Such social security should be provided by contributions from employers, employees, self-employed, and government in fair proportions."

In 1946, testifying before the Senate Committee on Education and Labor, Monsignor John O'Grady, executive-secretary of the National Conference of Catholic Charities, said:

"It is generally recognized that in spite of the great advances that have been made by organized voluntary efforts and by local welfare agencies in providing medical and hospital care for the American people, we still have a large number of people who are not adequately protected. Our problem is to extend coverage without interfering with the gains that have been made as well as with the further gains that are bound to be made in the future by voluntary efforts of all kinds. . . . It is clear as daylight to me that they cannot do it all, that you need a governmental system, and a large area will have to be covered by government. But government ought to work with the existing facilities. My feeling is that we ought to have a universal prepayment plan."

The purpose of citing these opinions is not to give public health insurance in the United States "Catholic approval" or "Catholic disapproval." These statements are quoted, because these Catholic sociologists have attempted to apply Christian social principles to the problem of the advisability of a public health insurance program in the United States. The world is greatly in need of men who will bring "Christianity into the market place." It is not enough to theorize; it is also important to apply principles.

IV

This paper would be incomplete if it did not try to describe the characteristics of a good health insurance program. The moral principles applicable to health insurance and to the role of government have already been stated. Keeping these principles in mind and the desirability of respecting the rights of the doctor and his patient, we shall attempt to outline some basic technical principles for a sound program of public and private health insurance.[6]

(1) Under any health insurance program all the parties concerned should be told, in the simplest, non-technical language possible, that the freedom of the doctor, patient, and hospital will be preserved. The public should realize that no person will have to take castor oil—if he does not want to take it; that he will not be compelled to go to a certain doctor—or else; that he has the freedom to change doctors and to select any doctor from a panel; that no doctor has to participate under the plan and that he can reject patients that come to him.

(2) Health insurance should not organize or direct the service of the physician,

---

[6] For several ideas in this section I am indebted to Michael M. Davis, "You Can Get It If You Go For It." Survey Graphic, September 1946, 35 (9) : 317–18.

dentist, surgeon, or hospital, but only the methods by which the people pay for such service. The professions should be responsible for all strictly medical activities.

(3) There should be national standards of administration and distribution, but the administration of the program should be decentralized. The maximum amount of responsibility should reside locally. The big advantage of decentralization is freedom. It is easier for doctors, hospitals, and patients to have their complaints and importance recognized on a local basis.

The local housing authorities under the Federal Housing Agency are good models of a national program with local administration. The authorities are sponsored and partially financed by the Federal Government but are administered and operated by a board of local citizens.

The local boards directing the insurance program would include representatives from professional groups, hospitals, consumers, labor unions, and industry. Administrative policies would thus be determined by those who receive and furnish the service. These local committees would, of course, have to recognize the traditions and practices of the medical and hospital professions.

(4) Voluntary organizations which provide hospital and medical services should not only be protected but should also be encouraged under a national health plan. If this principle were written into health insurance legislation, it would prevent people from using health insurance as a wedge to abolish non-profit organizations and to create a federal monopoly of medicine. The protection of voluntary organizations would encourage every man to provide the best possible medical aid for himself and his family.

(5) As a matter of practical strategy, to win public support and to allay the suspicions of physicians and hospitals, the advocates of health insurance should point out that they are not interested in "socialized medicine" but believe that a combined program of public and private health insurance is the best guarantee of medical freedom.

(6) Payment into health insurance funds must be compulsory and cover as many groups as possible. The compulsion applies to the payment, not to the medical service. Contributions should be compulsory and widespread:

(a) to prevent large families from being burdened with unbearably high medical and hospital costs.

(b) to even up the risks of dangerous employments with those not so dangerous.

(c) to aid the poorer sections of the population whose medical buying power is very low.

The principle of compulsory payment recognizes that risks are many: death, accidents, sickness, unemployment, old age. One man may have to face all of them. Another may avoid all of them until he dies. Universal coverage, invoking the principle upon which insurance is based, spreads the risks.

Father William Gibbons, S. J., explains why this compulsory feature is necessary:

"Even though paid a wage sufficient to cover necessary insurance costs on a voluntary basis, many of the lower income workers will not take advantage of the opportunity, through greed, ignorance, and inertia. In this case they end up by becoming charges of the state and community, with no insurance provisions. Tax money and extensive charity are the only sources.

"In this connection it should be recalled that usually the lowest paid workers are the ones with the greatest risks and therefore in the voluntary scheme would have to pay the highest rates. This difficulty can be got around only by the government." [7]

Testifying before the United States Senate Committee on Education and Labor on May 7, 1946, Msgr. John O'Grady, secretary of the National Conference of Catholic Charities, stated:

"From the very beginning, a national health security program must have universal coverage. That is, a program that does not have universal coverage is not going to meet our needs.

"This does not mean that everybody will be included in one governmental system. It does mean, however, that everybody must be covered. Coverage must be compulsory in fact but voluntary in form. And what does this mean? It means that all those who now are covered by voluntary programs can continue in their present status. It means an opportunity and an incentive to provide new voluntary programs."

---

[7] **National Health Program, America, June 1, 1946, 75 (9): 168–169.**

(7) A health insurance program should provide all the basic medical and hospital needs. In the home there should be provision for medical care by a general practitioner and specialist, visiting nurse service, and ambulance service. In the doctor's office the patient should be allowed eye examinations, psychiatric advice, medical attention by general physicians and specialists, vaccinations, diagnostic and laboratory tests, periodic check-ups, physiotherapy, etc. In the hospital a sick person should be able to obtain medical care, bed and board, routine nursing service, drugs, medicines, laboratory examinations surgical care and the use of operating room facilities, X-ray examinations, plaster casts and bandages, etc.

One of the major defects of many present health programs is that they do not include some of the more costly items noted above. It is precisely these more expensive health costs that should be included under an insurance program. For it is these costs that handicap people most seriously.

(8) Special provisions should be made for people without any income who are unable to insure themselves against the risks of accident or bad health.

(9) The most economical system should be devised for collecting insurance payments. Probably this can best be done simultaneously with social security pay roll deductions for old age and unemployment insurance.

(10) Physicians and hospitals should receive adequate payment by methods which encourage quality of service and economy of cost.

CONCLUSION

Readers should not expect that health insurance will solve America's health problem. It won't. On the other hand there can be no solution to America's health problem without a national extension of the health insurance principle. Directly related to the health of this country's citizens are many other problems: the shortage of doctors and hospital facilities in many areas; the precarious financial position of many medical schools and private hospitals; the great need for new and better research facilities; racial discrimination in hospitals and clinics; and a dozen other problems. Health insurance is a partial but extremely important answer.

Many more things are needed: Doctors with vision who are willing to take a lowered income for the opportunity to do Christ-like service. Self-sacrificing hospital administrators who are willing to cooperate with community programs designed to serve the common good. A more responsible citizenry who will take ordinary precautions to protect their health.

America's health is everybody's problem: the doctor's, the hospital's the government's, the labor union's, and the citizen's. When all these groups understand what the facts about the nation's health are, when they recognize the way in which our society has disregarded the dignity of men in the field of health, the people of the United States will introduce a health program to give every man and woman an opportunity to live in a manner worthy of his dignity as a child of God.

LOYOLA UNIVERSITY, *Chicago 11, Ill.*

BIBLIOGRAPHICAL NOTE

In addition to the references already cited, readers of the REVIEW are referred to the following Catholic sources for information and comment: James E. Murray and Robert A. Taft, "Compulsory Health Insurance, Yes? No? Sign, Pp. 35–38. April 1947; anonymous, "Must It Be Socialized Medicine?" Commonweal, 40 (24) : 558–63. September 29, 1944; W. F. McKee, "Medical Care Insurance for All," The Liguorian, 9 (2) : 35–38. February 1945 (Abridged in Catholic Digest, 9 (4) : 41–45. April 1945) ; William J. Gibbons, S. J., "The Why of Social Security," America, 74 (5) : 124–5. November 3, 1945; Robert C. Hartnett, S. J., "A Round Table on Public Health Insurance," ACSR, 6 (3) 177–80. October 1945.

The Institute of Social Order (3115 S. Grand Blvd., St. Louis 18, Mo.) has issued a 29 page mimeographed outline entitled: "Catholic Opinion on a National Health Plan." It includes a bibliography.

Various issues of Hospital Progress since 1944 have carried detailed comments on current proposals for health insurance. The Catholic Hospital Association has issued several booklets critical of congressional proposals for health insurance. See especially Father Alphonse M. Schwitalla, S. J., A National Health Program and the Wagner Bill.

The syndicated weekly column, "The Yardstick," of the NCWC news service has carried comments on health insurance by Father Raymond A. McGowan and Father George G. Higgins. See especially columns in December 1945 and July 1946.

For month-to-month comments on health insurance proposals since 1943, see various issues of Work, publication of the Catholic Labor Alliance in Chicago.

HEALTH SERVICES IN NEW ZEALAND

By Hugh MacLean, M. D., F. A. C. S., and Dean E. McHenry, Ph. D., Los Angeles, Calif., 1947

This study was conducted by the authors in New Zealand while Professor McHenry was on a fellowship for the Carnegie Corp. Dr. Hugh MacLean is a physician and surgeon, formerly in practice in Regina, Saskatchewan, Canada, now in Los Angeles. Dean E. McHenry is associate professor of political science and dean of social sciences, University of California at Los Angeles.

Among the free nations of the world, New Zealand has done the most advanced experimenting with state intervention to furnish health services for all of the people. It is now 10 years since provision for health benefits was written into the Social Security Act of 1938. The New Zealand plan for bringing medical care to all has been roundly condemned by the organized profession, both in the Dominion and overseas, and has been admired rather overcredulously by reformers at home and abroad. Actually, however, no comprehensive study of the scheme has heretofore been published in North America.

The essential features of the New Zealand system of health benefits is that the state pays for basic medical, pharmaceutical, hospital, and some other services. Health benefits are universally available to the whole population without means test of any kind. Funds are raised through taxation. In compensating general practitioners, both capitation and fee-for-service methods are used, but the overwhelming majority uses the latter. Pressure from the profession led to three major concessions: the fee-for-service plan, the right of the doctor to charge the patient more than the fixed fee, and state refund to the patients rather than direct collection by the doctor from the state fund. With these modifications, nearly all physicians in the country are practicing under the act, although the organized profession and the Government have not been cooperating to the extent necessary for a proper functioning of the scheme.

GENESIS OF THE NEW ZEALAND SYSTEM

Health services in New Zealand, before the advent of the Labor Government in 1935, bore general similarity to those of other English-speaking countries. Most practitioners engaged in individual practice, and their compensation came mainly from fees for professional services collected by them from their patients. Except for the friendly societies and fraternal orders, there was little prepaid medical care. In New Zealand, as in other countries, doctors accepted payments for workmen's compensation cases from insurance funds.

While the major features of medical practice were similar to those in the United States, Great Britain, and the other Dominions, a number of developments in auxiliary health services were rather unique. First, extensive public hospital facilities had been provided. These are managed by local elective hospital boards, each of which has jurisdiction over one of the 42 districts into which the country is divided. Prior to the Social Security Act, local hospital boards relied for their finances mainly in fees from patients who could afford to pay, and from rates (land taxes). Counting all hospital beds, public and private, in 1945 there were about 10 beds per 1,000 population.

Second, free dental services in the schools were well established. A fairly complete state dental service was gradually made available to primary pupils, beginning with the younger children in 1919. Third, great progress has been made in infant care through the "Plunket movement" founded by Dr. Sir Truby Kind in 1907.[1] The infant mortality rate of the Dominion consistently is one of the world's lowest, and credit is generally given for this achievement to the Plunket system of feeding, training of mothers, hospitals and nurses. Although state subsidies are now received, the movement was started with private subscriptions and still relies heavily upon them.

---

[1] The name comes from the wife of the then governor general, Lady Plunket, who was patron of the movement.

In addition, two other factors that affect health services should be borne in mind. Most New Zealand medical practitioners were trained in the Medical School of the University of Otago, in Dunedin. The standards of the medical school are high, and its graduates have made remarkable records in postgraduate work in England and Scotland, and occasionally in North America. Finally, the geographic features of New Zealand affect the health of the people. Its remote situation and "mild but raw" climate serve to keep down some of the communicable diseases. Its sparse population and rugged terrain left many rural areas without adequate medical care or access to hospitals.

Health policy of the Labor Party.—The New Zealand Labor Party won a decisive victory in the general election of November 1935, and has governed the country continuously since that time. Like the Labor Party in the United Kingdom, it is a nondoctrinaire and mild socialist party, more inclined to extend social security than to transform society. Its health program was only one unit among a number of new and expanded social services.

Early Labor programs and platforms contained little on the subject of medical care. Following the ordeals imposed upon the party during World War I, annual conferences began to adopt in piecemeal fashion various policy remits that eventually were codified and called a platform. The earliest mention of medical services appears to be that contained in a statement of educational policy adopted by the 1921 conference.[2] There, and in the formal platform issued the following year, the party listed "free medical attention" among educational services.[3] Presumably this was intended for school children only. In the last compilation of platform appearing before the 1935 election, a similar item is included under "Education," reading: "Free medical attention to be available to all pupils attending schools."[4] "Health" is a separate heading just before "Education," and contains three clauses:

"(1) Nationalisation of the medical service, with free medical, dental and maternity attention.

"(2) The establishment of a State Housing Department for the purpose of providing better homes for the people, and at less cost by the elimination of private profit.

"(3) The establishment of baby clinics, at which the best medical skill and attention shall be available free of cost."

In Labor's election manifesto of 1935, a "National Health Service" is promised, that would:

> "(*a*) Give every citizen the right during ill-health to call in his own medical practitioner, to consult and receive the services of specialists where required, and by the reorganization of our Hospital System, to make available all other services that are necessary for the restoration and maintenance of health.
>
> "(*b*) Extend the home nursing service so as to provide all the attention necessary for mothers and other members of families when it is not convenient for them to leave their own homes. The Labor Government will provide the necessary laboratory facilities to maintain the efficiency of the services, together with adequate payment to practitioners and others who carry out the work. The service will be available for every family."[5]

Another section of the manifesto contained the declaration: "Health services should be made as freely available as educational services."

In view of its platform and manifesto declarations, the Labor Government that took office late in 1935 considered it had a mandate to establish a health scheme with a broad variety of benefits, universal in application and free of payment for specific services by the patient.

Shortly after the new Government took office, it was announced that the Minister of Health, Mr. Peter Fraser, was considering a national health scheme, and that Dr. D. G. McMillan, a Labor member of the House of Representatives (M. P.), was helping to formulate it. In 1934, at the age of thirty, Dr. McMillan made a deep impression upon delegates to the annual party conference by what Mr. Fraser called "* * * an eloquent and deeply sincere speech on the subject of a National Health Programme for Labor." [6] He had written the only Labor pamphlet on the subject of health services, was the only physician among Labor M. P.'s elected in 1935, and therefore occupied a very strategic position in organizing the health plan.

---

[2] Maoriland Worker, August 24, 1921.

[3] Maoriland Worker, September 27, 1922, carries the text of the party's platform.

[4] New Zealand Labor Party, "Objective and Platform" (mimeographed, no date), but contains notation that as amended at 1934 conference.

[5] New Zealand Labor Party "Labor's Election Policy" (mimeographed, no date), p. 6. The term, "National Health Insurance Scheme" is used alternatively. Cooperation with the friendly societies, the medical, pharmaceutical, dental, and nursing professions was pledged.

McMillan's views are expressed in A National Health Service.[6] His main criticisms of the British health insurance scheme were the limited services provided and the lack of universal coverage. The principles he laid down for a service in New Zealand were stated in the following terms:

"Our New Zealand National Health Service must be 'free.' It must be complete; it must meet all the needs of all the people, and it must be characterized by six main essentials."

"1. It must aim at the prevention of disease."

"2. It must make provision for income * * *" (lost through illness).

"3. It must provide all the facilities for the diagnosis and treatment of disease."

"4. It must be based upon the provision of a family doctor for every person."

"5. The service must be founded upon the principle of the patient's free choice of doctor."

"6. It must include adequate provision for research in all matters relating to health." [7]

The service could be financed, he said, either by special levies based on ability to pay or out of the consolidated fund, but he commented that "* * * noncontributory insurance has the advantage of administrative simplicity and cheapness." [8] Dr. McMillan anticipated a wide range of services—general practitioner, specialist, nursing, hospital, pharmaceutical, and other—all free. There is abundant evidence that Dr. McMillan's views had much to do with the form and contents of the health sections of the Social Security Act. The aspect in which his outlook was most decisive appears to have been in the stress placed on the key role of the general practitioner; the family doctor who has a "thorough knowledge of the patient" and "long and personal contact."

Attitudes of the medical profession.—The medical profession of New Zealand was ill prepared to deal with popular and political demands for a national health scheme. A thoughtful warning had been given in early 1935 by Dean C. E. (now Sir Charles) Hercus of the Medical School, University of Otago. He told of the sorry plight of the British medical profession at the time Lloyd George brought into Parliament health insurance legislation. In country after country the profession failed to provide effective leadership in the formulation of health plans. Dean Hercus concluded:

"No lesson stands out more clearly than that the profession should keep in the closest touch with those engaged in drawing up even tentative schemes and should be prepared to advise and direct development along the lines which are essential to the sound practice of medicine." [9]

Although the British Medical Association, New Zealand Branch (hereafter designated as BMA), did establish a "national health insurance committee," brought Sir Henry Brackenbury, M. D., out from England to consult, and carried on a lively discussion of issues in its Medical Journal, the profession neither proposed a realistic, compresensive scheme itself nor did it manage to maintain close contact with the Government while the provisions of the Social Security Act were being formulated.

The BMA position was defined in some detail in a letter dated July 6, 1937, and addressed to the secretary of the committee of Labor M. P.'s appointed to advise the Government on health insurance.[10] The population would be divided into four groups, and health services provided on the basis of their capacity to pay for themselves. First, pensioners, unemployed, and others with comparably low incomes should receive a complete health service wholly at the expense of the state. Second, wages and salary earners with modest incomes would receive full services and would pay for the larger part of them. Third, persons not covered in the first two categories and below £500 and over should make their own arrangements for health services, with the option of coming under the third plan if they chose.

---

[6] D. G. McMillan, A National Health Service, New Zealand of Tomorrow (Wellington: New Zealand Labor Party, 1935), foreword by Peter Fraser, p. 3.

[7] D. G. McMillan, op. cit., p. 7.

[8] Ibid., p. 8.

[9] C. D. Hercus, Health Insurance in New Zealand, New Zealand Medical Journal, vol. 34 (April 1935), pp. 85–97.

[10] The letter appears in appendix "B" of the report of the McMillan committee, which was officially known as the National Health Insurance Investigation Committee. Its report was issued in mimeographed form on September 4, 1937.

In discussing administration of the proposed scheme, the BMA stressed, quite properly, that the medical profession should play a major part in managing health insurance. The plan outlined by the BMA in 1937 bore a general similarity to the health insurance scheme then in force in the United Kingdom. The British plan, however, involved only two categories of the population, those covered and those exempt. Coverage included all manual workers and nonmanual workers making £250 or less per year. The British plan did not include the families of employed persons.

Formulation of the Government's bill.—Both the Government and the BMA must bear some responsibility for the lack of consultation and compromise over the medical benefits of the Social Security Act. A committee of Labor M. P.'s was appointed to advise the Government. Under the chairmanship of Dr. McMillan, it held hearings around the country. BMA leaders testified before the committee, although they did entertain doubts about its composition and personnel:

"It did contain as chairman a member of the medical profession whose highest qualification for the position was a political one, a man who already had strong preconceived ideas on the subject, based on no personal knowledge of medical practice except his own relatively limited experience in this country." [11]

The McMillan committee began its investigation by preparing and sending a questionnaire to 10 groups that would be most affected by the proposed health legislation: Physicians, hospitals, friendly societies, chemists, dentists, masseurs, nurses, opticians, ambulance societies, and life insurance offices. The questions concerned coverage, finance, benefits, and other matters. The report does not give a clear statement of the replies received, rather the committee mixed its own views with those of the respondents and presented rebuttals to the replies with which it disagreed. Recommendations of the committee then followed:

A universal, national health service ought to be introduced. Medical benefits should begin with general practitioner, maternity, and auxiliary services, and later be expanded to specialist, nursing, and other fields. Pharmaceutical and hospital benefits would be instituted at once. Dental service, limited initially to extractions and provision of dentures, and expansion of the school dental service, was recommended. Aid to medical research and added support for health education were endorsed by the committee.

The committee argued in strongest terms for the universal principle, and attacked with vigor the BMA position of classifying people into income classes. "Unlike overseas people," the committee declared, "self-respecting, freedom-loving New Zealanders will never respect or tolerate a service which gives one type of service to the poor and another type to the well-to-do. Any scheme which savors of a poor-man service, of charity, which divides the people into two groups, those able to pay private fees and those unable to do so; which differentiates in the mind of the doctor, either consciously or unconsciously, between patients would be foreign to the ideals and aspirations of the Government in particular and the people of New Zealand in general." [12]

Apparently the McMillan committee considered only capitation as a means of remunerating doctors for general practitioners' service. Fee for service was not mentioned in the report. The committee did propose, however, that the maximum number of patients permitted on any practitioner's list should be 3,000. BMA representatives claim they did not see the report Dr. McMillan's committee made to the Government, nor was it published in a public document even after the Social Security Act was on the statute books. The Government and the BMA were increasingly suspicious of one another.

The next phase was dominated by the select committee of the House of Representatives known as the National Health and Superannuation Committee. It was established on motion of the Prime Minister, Mr. Savage, and included in its membership of eleven were Messrs. Savage, Nash, and Nordmeyer, who was elected chairman, and S. G. Holland, who subsequently became leader of the opposition. In April 1938 the Prime Minister submitted to the committee a memorandum containing the Government's social security proposals. Concerning health services, the white paper read as follows:

"(1) The Government proposes to provide:

"(*a*) A universal general practitioner service free to all members of the community requiring medical attention.

"(*b*) Free hospital or sanitation treatment for all.

---

[11] New Zealand Medical Journal, vol. 37 (October 1938), pp. 239–240.

[12] National Health Insurance Investigation Committee, report of * * *, pp. 13–14.

"(*c*) Free mental hospital care and treatment for the mentally afflicted.
"(*d*) Free medicines.
"(*e*) Free maternity treatment including the cost of maintenance in a maternity home.

"(2) The Government further proposes that these services should be supplemented, when organization and finances are available, by the following additional services:

"(*a*) Anesthetic.
"(*b*) Laboratory and radiology.
"(*c*) Specialist and consultant.
"(*d*) Massage and physio-therapy.
"(*e*) Transport service to and from hospital.
"(*f*) Dental benefit.
"(*g*) Optional benefit.

"(3) It is also proposed to institute a free home nursing and domestic help service when the necessary staff has been trained to make such a proposal practicable.

"(4) Complementary to the foregoing proposals, the Government contemplates an extended educational campaign for the promotion of health and the prevention of disease." [13]

Judging from the report filed by the committee, the majority was able to reach a verdict in favor of the Government's proposals promptly. Half of the ten-page report is taken up with a rebuttal of BMA arguments and with counterproposals. The committee report lists five main points made by the BMA:

"i. There is no need for a universal service while many people are able to pay for their own doctor and will prefer to do so.

"ii. That the development of friendly societies and the growth of our public hospital system renders unnecessary a scheme of the extent proposed.

"iii. That the proposal will lead to a deterioration of the standard of medical service.

"iv. That the adoption of the universal scheme will lead to those very distinctions which it is the object of the Government to avoid.

"v. That it may involve embarrassment to the commitments of medical men" [14] (through reduced earnings).

Having devoured the BMA's arguments, the committee proceeded to recommend to the government and the House favorable consideration of the proposed legislation.

The BMA officials claim that they were assured that opportunity would be afforded them to examine the proposed bill before it went before Cabinet and House, but the bill was sent through without being submitted to them.[15] Dr. Douglas Robb, outstanding Auckland surgeon, says:

"Indeed, only after the social security bill was introduced into the House were its contents made known to the BMA. There is no doubt that the bill was political in its conception, and that technical and professional considerations were almost entirely ignored." [16]

HEALTH BENEFITS UNDER THE SOCIAL SECURITY ACT

Health benefits were provided for under part III of the Social Security Act, 1938.[17] Five classes of health benefits are defined in the act: (1) medical, (2) pharmaceutical, (3) hospital, (4) maternity, (5) supplementary. The inaugural date for any benefit was to be fixed by the minister of health. All persons ordinarily resident in New Zealand are eligible for health benefits. Funds to finance the whole Social Security scheme are raised by a flat tax on all income (originally 5, now 7½ percent) and an annual levy on all adults (£1 for men and 5 shillings for women), which has since been repealed. Additional moneys needed to finance the whole social security program, monetary as well as health benefits, are secured by transfer from the consolidated fund of the state.

A mere summary of the act gives insufficient emphasis on its principles and characteristics. The law anticipated a universal coverage of the total resident population, regardless of economic status. In this respect it pioneered, for British and other health insurance schemes, up to that time, provided for limited coverage only, usually employed workers receiving less than a stated yearly wage. The original British health insurance left out not only families, but also omitted the unemployed and the employed who made more than the stated wage. The New Zealand act was also unusual in that it was noncontributory, benefits being made available to all as a matter of right, regardless of whether or not taxes were paid for the purpose. New ground was broken, also, in the comprehensiveness of the benefits provided for. Nearly every conceivable contingency was anticipated and an appropriate benefit defined. Never before in history, with the possible exception of Russia, had more complete cradle-to-grave protection been afforded to a people.

---

[13] New Zealand House of Representatives, appendix to the Journals, 1938, 1–6, "National Health and Superannuation Committee, report of the * * *," p. 2.

[14] Op. cit., pp. 5–6.

[15] New Zealand Medical Journal, vol. 37 (October 1938), p. 242.

[16] Douglas Robb, Health Reform in New Zealand (Christchurch: Whitcombe & Tombe, 1947), p. 11.

[17] George VI, 1938, No. 7.

The election of 1938 followed shortly after the passage of the Social Security Act. No issue held greater interest for the voters than that of social security, and the Labor Party made the most of its popularity. Party literature called the 1938 act "* * * the greatest piece of humanitarian legislation ever passed by any government in the history of the civilised world."[18] The labor election manifesto declared:

"The Social Security legislation now on the Statute Book will ensure to every member of the community, full and adequate hospital, sanitoria, medical, pharmaceutical, maternity and other health services. Provision has been made for vigorous measures aimed at the prevention of disease."[19]

Even during the campaign it was clear that the organized medical profession would not cooperate in the inauguration of the scheme. The BMA denounced the medical benefits section of the Social Security Act in the strongest terms:

"The Act determines the complete socialization of the profession and institutes a system of medical service which has been aptly described as 'demoralizing to those that give it and destructive to those who receive it,' a service providing the poorest type of treatment known to the medical profession. For the benefit of the health of the people of New Zealand in the future and for the preservation of all that is best for the profession of medicine, it is our duty to oppose to the uttermost this ill-conceived measure so strongly tainted by party politics."[20]

The Auckland president of the BMA was reported as declaring: "New Zealand doctors throughout the length and breadth of our country will not work the scheme."

An equally belligerent mood was in evidence among labor leaders. Questioned regarding the BMA attitude of noncooperation, Mr. Savage stated: "The Government will see that the law as passed by Parliament is carried out."[21] Mr. Fraser, the Minister of Health, warned that if the profession continued its opposition, the Government "reluctantly" would be compelled to reconsider and introduce a "state medical service".[22] The Standard, weekly paper of the labor movement, headed an editorial on the subject: "Who Shall Govern?".

In January 1939 the Minister discussed with BMA representatives the possibility of providing health benefits on the basis of fee for service, but the profession was unwilling to make suggestions or proposals.[23] Beset with administrative problems connected with launching this huge program, the Department of Health moved slowly. The first benefit, free treatment in state mental hospitals, was put into force April 1, 1939, without opposition.

Maternity benefits.—The second class of benefits, maternity, was made available May 15, 1939. The services of hospitals, nurses, and physicians were involved under maternity benefits, and the first battle between government and BMA was fought over the terms of the contract between the Department and the medical practitioner. The success of the BMA in persuading doctors to withhold their services until more satisfactory terms were offered, encouraged elements in the profession favoring obstruction in the general practitioner field.

Contracts for maternity services were offered in April. Robb states that only two doctors accepted the contract. Further negotiations with the BMA led to revisions contained in the Social Security Amendment Act, 1939. The main provisions for maternity medical services, as revised, are as follows:

---

[18] Leaflet printed by the Standard Press, Wellington.

[19] New Zealand Labor Party, 1938 General Election (mimeographed; no date), p. 2.

[20] New Zealand Medical Journal, vol. 37 (October 1938), p. 242.

[21] Standard, April 13, 1939.

[22] Standard, May 18, 1939.

[23] New Zealand Medical Journal (January 31, 1939), supplement, p. 9.

(1) a scale of fees is fixed by agreement between the Minister and the BMA;

(2) "every doctor affording services covered by the scale of fees must accept the fees from the fund in full satisfaction of the claim for the services" with two exceptions

(*a*) doctors who notify the Minister they will not provide services under the act, and

(*b*) obstetric specialists who are permitted to charge the patient over and above the basic fee.[24]

The basic medical fee for maternity cases was set at £5 5s, and was raised to £6 6s in 1946, and appears to be considered reasonable by the medical profession. In 1940, the Department reported that six practitioners declined to work under the act; in 1943 the number had declined to five. In order to collect the full maternity fee, the doctor must report five antenatal and one postnatal attendances, and must have been present at delivery. Obstetrical specialists are those so recognized by the Minister. Application for such status is made by a practitioner; a recommendation is made by the BMA, and the Minister makes the final decision. Among the criteria used are proportion of practice devoted to obstetrics and membership in the Royal College of Obstetrics and Gynecology. In 1940, 22 were recognized as obstetric specialists. Only specialists and noncooperating doctors may charge a patient more than the basic fee of £6 6s.

It is very difficult to compare New Zealand and American professional fees. On the current exchange, £NZI=$US3.26; 10 shillings=$1.63; 1 shilling=16.3 cents; 1 penny=1.36 cents. To get a true picture, however, one must consider buying power. An American dollar (6s. 2d) will buy 4 pounds of butter or about 25 pounds of bread or an 8 pound beef roast. Rent is cheaper than in the United States. Manufactured goods cost more. All things considered, the average physician in New Zealand makes a good living and probably occupies a higher income level than any other trade, profession, or group in the Dominion.

Hospital services for maternity cases are free or partially free, depending on the ownership of the hospital and the terms of the contract between the Department and the particular institution. Hospitals operated by public hospital boards and the State-owned St. Helens Hospitals (located in the four main cities) accept the social security payment as payment in full. Private maternity hospitals, almost without exception, have entered into contracts with the Department. Of the 201 under contract in 1943, only 31 accepted the allowance from the fund as full payment, and all others made additional charges to the patient.[25] The basic charges that may be claimed from the fund are £2 5s. for the day of delivery and 12s. 6d. per day for up to 14 days of hospitalization.

The third type of maternity benefit, obstetric nursing in the patient's home, makes possible proper attendance in cases where a hospital is not used. Nearly 300 nurses have contracted to render such services, but the number of claims is only a small fraction of those made for hospital services. For full-time domiciliary services, nurses are paid 13s. per day up to 14 days; for part-time visiting services, 5s. per day for the same time limit. Provision is also made for delivery by midwives.

For an annual cost to the State of between £500,00 and £600,000, or around 6s. per capita, New Zealand has removed most of the financial burden of childbirth from the family and placed it upon the community. In so doing, it has made medical care available in maternity cases, regardless of the ability of parents to pay. The scheme has not yet operated long enough to assess the social consequences of maternity benefits. The most crucial questions in this field appear to be: (1) Can New Zealand's infant mortality rate, already one of the lowest in the world, be reduced still further? and (2) will the maternity benefits increase the birth rate and the size of the families? The impact of the war has made statistics of the era 1940–47 period difficult to evaluate. The introduction, in 1946, of universal family allowances, without means test, may make differential diagnosis difficult in the future.

Maternity benefits have been the most satisfactory of the main classes of health benefits under the Social Security Act. They are comparatively easy to administer and difficult to abuse. An absolute check over practitioner, patient, and hospital exists in the form of birth records. Perhaps greatest public support would be given to this aspect of health benefits, thanks in part to the great educational work done by Sir Truby King, and the monuments of his endeavor—the Plunket movement and the Karitane nurses.

---

[24] New Zealand House of Representatives, Appendix to the Journals, 1940, vol. III, H–31, "Director General of Health, Annual Report of the * * *." p. 7

[25] New Zealand House of Representatives, Appendix to the Journals, 1943, H–31, "Director General of Health, Annual Report of the * * *," p. 6.

Hospital benefits.—Hospital benefits, for other than maternity cases, became effective for in-patient treatment on July 1, 1919. In practice this means that hospitalization is free in public hospitals run by hospital boards and in semipublic hospitals like the Karitane baby hospitals. Private hospitals may collect from the fund the 9s. per day per patient allowed to board hospitals, and from the patient whatever extra charge is approved by the minister. The amount allowed varied with the accommodations provided, e. g. private room, two bed, or four bed rooms.

Out-patient treatment by board hospitals was included in hospital benefits beginning March 1, 1947. The fund simply subsidizes the hospital board operating an out-patient service with a grant covering 60 percent of costs of that service.

Charges on the social security fund for hospital services are larger than for any other class of health benefit. The total yearly cost to the fund has been over £2,000,000 per year since 1943–44. To arrive at the total bill for hospital services, paid for from public funds, one must add to the above sum another £1,000,000 which hospital boards receive from local government taxes on the unimproved value of land. Other smaller sums must be included to cover the cost of mental, convalescent, and other hospitals maintained by the State out of general funds.

What has the hospital benefit done to the hospitals? For one thing, it has been a factor in filling them to capacity and has necessitated their extension. Far from relieving hospital boards of financial burdens, it has added greatly to their responsibilities and their costs. This arises from the fact that 9s. per day does not pay the full cost of keeping a patient in a hospital, and the extra amount must be raised by the land tax. The charge is sometimes made that the availability of hospital benefits has caused a large number of chronic and minor cases to fill hospital bends, leaving a minimum of space available for cases in great need of hospitalization.

The medical profession, as represented by the BMA, has become concerned over the fate of the private hospital, lest the doctor in private practice lose his "workshop" and the trend toward State salaried service be accentuated. It is rather paradoxical that the two methods proposed for strengthening the private hospitals involve State action: (1) increasing Government subsidies, and (2) securing higher fees through an order of the stabilization authorities.[26]

Medical benefits.—The Government delayed until 1941 opening up the Pandora's box of general medical benefits. It was in this field that the BMA had uttered its most shrill challenge, and in this field the medical profession enjoyed, through the solidarity of its organization, a virtual monopoly over the manpower necessary to operate any such scheme. Here, indeed, was the battle that would decide the course of the war between the Government and the BMA. On the Government side, there was a reassignment of responsibilities; Peter Fraser had become the Prime Minister on Mr. Savage's death; after a brief transitional arrangement the portfolio of Health was turned over to A. H. Nordmeyer.

A. Capitation plan

The first big jump was made on March 1, 1941, when medical benefits under the capitation scheme were made available. People were entitled to choose medical practioners and to enter into agreements with them for general medical services, excluding maternity and specialist services. The fund would compensate cooperating doctors at the rate of 15s. per year for each man, woman, and child on the practitioner's list or panel. The doctor is also entitled to receive a mileage allowance for each patient residing from 3 to 20 miles away. The procedure is similar to that under the British health insurance scheme. The patient had free choice of doctor and the doctor could accept or reject patients. No limit was placed on the number of patients a doctor could have under the capitation plan.

The BMA had been girding its loins for such an announcement for a long time. In 1938 it had inaugurated a fund to assist practitioners who might otherwise be forced to accept service under the act. The BMA advocated noncooperation and was gratified that only a small number of practitioners signed up under the capitation plan.[27]

---

[26] New Zealand Medical Board, vol. 46 (February 1947), pp. 56–57.
[27] Douglass Robb, op. cit., p. 17, estimates 40 or 50.

Capitation is still in operation, but has declined fairly steadily in use. Charges on the fund for capitation services were £55,612 in 1943–44, £42,400 in 1944–45, and £38,084 in 1945–46.[28]

In some sparsely settled areas, capitation appears to have worked well. Some practitioners in urban areas took to the plan, and found large monetary rewards were possible through it. The health department, in noting the reduction in use of the capitation plan, commented in 1945:

"This was to be expected, as the capitation scheme has certain disadvantages to both doctor and patient when working side by side with a fee-for-service system. The capitation system, however, is sound in principle, and it has yet to be proved that it is not the most satisfactory form of medical insurance practice." [29]

When the BMA conducted a plebiscite of its membership in 1945, only 14 doctors reported conducting practice under the capitation plan, but 35 said they preferred the capitation system over other plans.[30] After Mr. Nordmeyer explained to the 1942 annual conference of the Labor Party that the fee-for-service system was "only a stop-gap," the conference reindorsed the capitation system.[31] Despite the determination of the Labor people to the contrary, it appears that the BMA will determine, by negative action if not by positive, the remuneration scheme to be used.

It is doubtful if the majority in the medical profession will ever be reconciled to the capitation system, so long as the coverage is universal and service is free. New Zealand doctors developed a prejudice against capitation as it operated under British health insurance, partly because of the low remuneration offered. In the report of the BMA medical planning committee, further consideration of the capitation system is conditioned upon: "A definition of the content of general practitioner service would have to be made, a schedule of duties drawn up, and all beyond that should be left open to charge of fees, subject to the refund principle." [32] Much of the BMA attack upon capitation as introduced in 1941 centered around the argument that it would make difficult the reentry into practice of medical men then in the armed forces.

The BMA freely conceded the advantages of the capitation plan from the Government's point of view. The costs of operation could be computed with considerable exactitude. Administration is rather simple. The BMA contended, however, that an unfair burden of risk was placed upon the practitioner, who must provide medical services for a set amount per year regardless of the amount of illness encountered.

B. Fee-for-service system

Soon after the capitation plan was inaugurated, it became obvious that the medical profession would not cooperate under that system to an extent sufficient to get medical care to all of the people. The Government then began to consider seriously the instituting of a fee-for-service plan. Its initial proposal was for a fee of 5s. per attendance in the doctor's surgery and 6s. 6d. in the patient's home. There was an outcry in the profession. Eventually the Government compromised on two points. The scale of fees was raised to 7s. 6d. for an ordinary weekday consultation, in either office or home, and to 12s. 6d. for a night or Sunday call. The right to charge over the fixed amount was also granted. At the time the labor caucus and cabinet yielded on the latter point, those who were negotiating with the BMA for the Government were under the impression that some 90 percent of the doctors would accept the set fees as full payment. The fee-for-service system was put into effect on November 1, 1941.

The BMA then adopted the stand that the profession should carry on as usual, and continue to charge normal fees. This is called the "refund plan." Professional services would be rendered and the patient billed for the customary amount. On receiving payment, the doctor issued a receipt to the patients, who could submit it, along with an appropriate form, and secure a refund of the fixed amount allowed from the fund. A common fee for an ordinary daytime consultation is 10s. 6d. (half a guinea). The patient pays, receives a receipt, submits the receipt and proper form, and gets back from the fund the 7s. 6d. allowed. The Government prefers to have the doctor claim payment direct from the fund, and accept the reimbursement allowed as full payment for his service; this is the "direct claim" method of remuneration. A third variation has arisen in practice: the doctor claims direct from the fund, but also requires the patient to pay him an additional amount; this is known as the "token" system.

---

[28] Figures from annual reports, Appendix to the Journal.

[29] New Zealand House of Representatives, Appendix to the Journal, H–31, "Director General of Health, Annual Report of the * * *," p. 11.

[30] New Zealand Medical Journal, vol. 44 (October 1945), supplement, pp. 3–4.

[31] Standard, April 16, 1942.

[32] Medical Planning Committee, Draft Final Report, New Zealand Medical Journal, vol. 43 (July 1944), supplement, p. 8.

1. *The refund plan.*—Refund, the method of remuneration favored officially by the BMA, involves the payment of the doctor's fee in full by the patient, who may then receive the set amount allowed from the social security fund. The only variation from the traditional practice in this scheme is the requirement that the practitioner provide a receipt for the patient. Except insofar as patients consult their physicians more freely since they know a part of the fees are refundable, the normal pattern of practice is not interfered with. A committee of the BMA summarized the advantages of this system as follows:

"This method causes the least interference with normal conduct of practice. The relationship of doctor and patient is not intruded upon by any interested third party. The doctor can give his patient the attention and service he requires, and graduate his charges thereto. The patient retains some responsibility for his own treatment, which is not a negligible matter, while obtaining return for his taxation without temptation to overdo it." [33]

It also is argued that the receipts issued constitute a full record of a doctor's earnings for tax purposes. Neither patient nor doctor, the BMA claims, is likely to abuse social security funds under the refund plan. In its referendum of 1945, the BMA received replies from 368 general practitioners, of whom 221 conducted the practices under the refund system, but only 172 indicated their preference for refund over other systems. [34]

The Department of Health has found the refund system difficult and very expensive to administer. Around 30 percent of the refund forms are incorrectly filled out by patients, necessitating further correspondence and delay before payment can be made.

2. *The direct claim plan.*—Direct claim, generally called fee-for-service in medical circles, means that the doctor provides services for the patient, secures the patient's signature on the appropriate form, which the practitioner submits to the Department of Health in order to receive remuneration from the fund. He accepts such compensation as payment in full, and receives nothing from the patient directly. The Government favors this plan, for it greatly simplifies the administrative procedure and is less costly. The forms submitted by the doctors, with few exceptions, are correctly filled out. Only a relatively small number of payments are required to satisfy all direct claims made by doctors, whereas the refund system involves millions of payments to patients per year.

The BMA argues that patients may call upon a physician for service unnecessarily if that service is entirely free, and that some doctors will make an excessive number of calls in order to collect the additional fees. The danger of the patient overdemanding services certainly exists in both capitation and fee-for-service schemes. It is difficult to see how a conscientious doctor would overvisit under any system. Basically the profession opposes the direct claim plan because it interferes with the traditional method by which the doctor collects his fee for services rendered.

In the BMA referendum, 110 of the 368 general practitioners reported they were operating under the fee-for-service (direct claim) system, and 135 stated that they preferred that system.[35]

3. *The token system.*—Out of the fee-for-service plan, with its provision for remuneration either by refund or direct claim, emerged a third variation which combines features of both. The doctor makes a direct claim for the statutory fee and also receives an additional payment from the patient. The profession has given this mixed method of remuneration the name of "token." A common example of token is for the doctor to charge 3s. above and beyond the amount he will collect directly from the fund.

From the beginning the BMA branded the token plan as undignified, despicable, and possibly illegal. The BMA medical planning committee declared: "It is the equivalent of asking for a tip."[36] An opinion that the token method was illegal was obtained from counsel for the BMA,[37] but Department of Health officials found nothing illegal about it. BMA spokesmen also condemned the token plan because it allegedly permits dishonesty and tax evasion. Certainly refund provides tax authorities with receipts that can be checked against income tax returns, but the token plan offers no more temptation to evasion than the presocial security methods of collecting in full from the patient.

---

[33] Medical Planning Committee, Draft Final Report, op. cit., p. 7.

[34] Report of Referendum Subcommittee, New Zealand Medical Journal, vol. 44 (October 1945), supp., pp. 3–4.

[35] Report of Referendum Subcommittee, op. cit., pp. 3–4.

From the department point of view, token is preferably to refund, largely because direct claims from doctors are easier to pay and cheaper to administer than refund applications. The patient has every reason to favor token over refund, because he is relieved of the necessity of filling out forms and going to the post office to cash his warrants. The doctor is protected against excessive calls by the patient through the same deterrent that operates under refund, namely the collection of a nonrefundable amount beyond the statutory fee.

At the time of the BMA referendum of 1945, the token system had been so thoroughly denounced by the medical planning committee as illegal that it is not surprising that few doctors were willing to declare they practiced under it. Only 18 of the 368 general practitioners answering stated they conducted their practice under token, and the same number declared they preferred it.[38] Letters from practitioners to the editor of the New Zealand Medical Journal denied the stigma of illegality and claimed the referendum question on token was prejudiced by "false information."[39]

After an exhaustive discussion and many votes, the council of the BMA decided in 1946 to empower the executive to negotiate with the Government on the token system.[40] Department records do not show what proportion of practitioners uses token, for all direct claims from doctors are grouped together. By 1946, however, around one-half of all moneys paid from the fund under medical benefits was paid directly to doctors. This may have been a factor in the BMA decision to reopen negotiations which may lead to the abolition of the refund system. Certainly the profession cannot indefinitey stand fast on the "principle" adopted in 1941, and reiterated in 1945, "to practice as hitherto and enable patients to claim a refund of the stautory fee."[41]

C. Salaried service.

The Social Security Act empowers the minister of health to make special arrangements in order to provide medical services for people living in remote areas. This has been provided mainly by salaried medical officers. The base salary is high enough to attract young doctors into sparsely populated areas that would have little chance of medical service under ordinary conditions. The salaries offered range from £1,100 to £1,700 per year, and the doctors are also permitted to charge fee-for-service for patients not ordinarily resident in the district. Eighteen physicians were in the salaried service in 1946.

One critic of the New Zealand system of medical care regards salaried personnel for remote areas as "logical and satisfactory."[42] The BMA committee opposes this salaried service, however, and proposes that these areas should be served by private practitioners, using the fee refund method, and collecting mileage from the social security fund.[43]

Fear of a universal salaried service may, in the long run, be a potent factor in making the organized profession adopt a more conciliatory attitude toward the Government proposals. The wholesale use of salaried service is unlikely to be resorted to by any Government without extreme provocation. During the war the shortage of doctors in the country gave the profession extraordinary bargaining power. The return of physicians from the armed forces and the graduation of new doctors from medical school is rapidly correcting the deficiency in medical personnel. If a complete break should occur between Government and BMA, it is conceivable that a general salaried service could be recruited from Great Britain and from those willing to cooperate within the Dominion.

---

[36] Medical Planning Committee, Draft Final Report, op. cit., p. 7.
[37] New Zealand Medical Journal, vol. 44 (February 1945), pp. 54–56.
[38] Report of Referendum Subcommittee, op. cit., pp. 3–4.
[39] Vol. 44 (February 1945), pp. 49–53.
[40] New Zealand Medical Journal, vol. 45 (April 1946), p. 130.
[41] Ibid., vol. 44 (April 1945), p. 116.
[42] The New Zealand Experiment, Journal of the American Medical Association, vol. 130 (Apr. 13, 1946), p. 1071.
[43] Medical Planning Committee, Draft Final Report, op. cit., p. 8.

PHARMACEUTAL BENEFITS

The promise of "free medicines" was redeemed with the inauguration of pharmaceutical benefits in May 1941. The Minister of Health entered into contracts with pharmacists, who agreed to fill prescriptions of medical practitioners for persons covered by the act. Pricing of each prescription is done according to a "drug tariff" issued by the department. In practice, employees of the department price every ingredient in each prescription, and then add the cost of container and the chemist's profit. A tremendous staff, estimated at 100 for the Dominion, is required to price prescriptions and reimburse pharmacists for services under the act. It is estimated that around 90 percent of all prescriptions in the country are paid for by the fund.

The cost of pharmaceutical benefits has been surprisingly high. The first full year of operation, 1942–43, the cost was 563,247; for 1943–44, 762,198; for 1944–45, 980,237; and for 1945–46, 1,133,366.[44] The large size of the drug bill is regarded by the department as "very disquieting." For 1945–46 the pharmaceutical benefits cost nearly as much as medical practitioner services. In one sense, it is the medical profession that must bear responsibility for overprescribing; there are innumerable instances of unnecessary and expensive prescribing. Actually, there are administrative procedures that can be adopted to reduce both abuses and cost of administration. The best hope seems to be the adoption of a set formulary from which doctors can prescribe, eliminating unusual and expensive ingredients.

SUPPLEMENTARY BENEFITS

X-ray diagnostic services were started in August 1941. At first limited to radiological services provided by hospital boards, in 1942 benefits were extended to such services provided by private practitioners. Those in private practice are divided into two groups: "absolute" recognition is extended to practitioners who are permitted to do all classes of radiological work; "limited" recognition is granted to those permitted to do only certain classes of work. Two sets of fees are in use: one for those with absolute recognition and one for those with limited. Radiological work done by hospital boards is paid for on the limited scale of fees. Claims for X-ray services are made by practitioners directly against the fund. Since 1944 the fund has paid more than 100,000 per year for radiological services.

Massage services, begun September 1942, are available to patients on the recommendation of medical practitioners. The contracts between Minister and masseur, permit the latter to collect 3s. 6d. from the fund for each office treatment, but he is not permitted to charge the patient more than 3s. 6d. additional. Virtually every masseur in private practice has entered contracts to provide service under the act. For the last 2 years, massage services have cost the fund more than £30,000 annually.

District nursing benefits, introduced in September 1944, make free to the patient the nursing services provided by hospital boards, various departments, and subsidized associations. For 1945–46 the cost to the fund for these services was £58,880.

Domestic assistance will be provided at fund expense under certain circumstances when a mother is incapacitated. Payment is made in the form of a subsidy to an association which provides such service.

SCHOOL HYGIENE

Although the School Medical Service was established 35 years ago, work in the field of school hygiene has expanded greatly since the Labor Government came to power in 1935. The early work of the Division of School Hygiene was confined largely to conducting physical examinations of primary school children, a function that still looms as very important in the school health program. The division aspires to examine school children three times during their primary careers: at entry, midway, and at graduation. Operating with only 14 medical officers out of an authorized strength of 24, the division conducted over 75,000 medical examinations of primary pupils during 1945.[45] Approximately 40 percent were found defective in one or more particulars; nearly 10 percent suffered from subnormal nutrition. Preschool children are also examined; in 1945 just under 7,500 tots received medical inspection. Diphtheria and whooping cough immunizations are given to both preschool and primary children.

---

[44] New Zealand House of Representatives, *Appendix to the Journals,* 1946, H–31, "Department of Health, Annual Report of the Director-General of Health," p. 25.

[45] Annual Report of the Director-General of Health, 1946, pp. 14–15.

Among the innovations of the Labor Government in child health are the milk-in-schools scheme, free apples, health camps, and aggressive health-education campaigns. The free milk plan was started in 1937, in order to induce children to consume more milk of good quality. When available, milk that is fresh, bottled, and pasteurized is served once daily to primary pupils. In areas where safe fresh milk is not available, supplies of powdered or malted milk may be furnished. During 1946 horse racing enthusiasts attributed the lack of lightweight jockeys on the race course to the school milk program. The free apple scheme was started in part to relieve the market of a surplus that developed when war in 1939 cut off export markets. It has been retained as a permanent feature of the school health program.

The health camp movement has developed extensively during the past 10 years. School children with correctable defects are selected by the school health officers and nurses to spend periods in the camps. Some are operated the year around, but most are summer camps. The camps are supported in part through sale of special "health camp" stamps which may be used for postage.

Since the appointment of an outstanding and aggressive director of the Division of School Hygiene in 1940, a persistent campaign of health education has been conducted. The long-run program centers around the school child. Every effort is made to expose him to the best information on health matters. The walls of every schoolroom in the land are hung with posters that exhort pupils to "Drink More Milk," "Get Your Vitamin C," "Eat Those Vegetables." Teacher training colleges have elevated health education to an important position, and in due course New Zealand's teachers will be fully prepared to lead school children in matters of health.

Work done with pupils, however effective, is not enough. The child's food and other habits are determined largely in the home, so if progress is to be made in this generation, parents must be educated too. If the father and mother are unsympathetic with the health lessons taught to the child, the learning is unlikely to "stick." Therefore many channels have been used to inform parents and the general public. Posters and placards are used in public buildings, railroads, trams, and buses. Radio broadcasts are used to hammer home the story of health. The director himself did a three minute early morning broadcast, beamed to fathers, daily for four years. A longer program is heard over a national network weekly. The division also conducts a travelling "health show," a fairly elaborate modern museum utilizing demonstrations, exhibits, lecturettes, and films with sound. During the day, this show is used for adolescent children; in the evenings it draws adults. The show is popular and is considered one of the most effective means of reaching the general public.

DENTAL SERVICE

The School Dental Service, now the National Dental Service, in 1946 celebrated its twenty-fifth anniversary. It was established in 1921 to make available to school children the early attention to teeth that is required to combat dental caries, which the director of the service has called "the most prevalent disease afflicting civilised peoples." [46] New Zealanders have notoriously poor teeth. Men inducted into the armed services in World War II were found to run 50 to 60 percent with artificial dentures and 23 percent complete upper and lower sets.[47] Of the 75,000 primary school children examined in 1945, only 2.99 percent of the European and 6.43 percent of the Maori children had perfect teeth; of the 7,500 preschool youngsters examined, 7,148 percent had caries.[48]

Perhaps the three most distinguishing features of New Zealand's Dental Service are the use of dental nurses, the comprehensiveness of its coverage, and the support of the dental profession. The idea of training and using dental nurses was conceived by Thomas A. Hunter, first director of the service, who recognized how slow would be the development if reliance had to be placed upon dentists, who were short in supply and whose level of compensation would soon exhaust available funds. Therefore primary reliance was placed upon young women, who receive two years of training and then are deemed qualified to conduct ordinary clinical operations under the general supervision of dental officers. The nurses fill teeth, make extractions, and perform other operations that usually would be done by a professional dentist. At first the dental profession was not fully convinced that dental nurses should be given such responsibilities, but eventually it was won over.[49] Students entering the Dental Service agree to serve a minimum of five years, two as student and three as dental nurse. Trainees are paid a small salary, and those that live outside Wellington, where the training center is located, receive a lodging allowance. In 1946 there were over 400 dental nurses at work in the country and nearly 200 more in training.

---

[46] J. Ll. Saunders, The Dental Problem in New Zealand in Relation to the Modern Conception of Health Services, New Zealand Dental Journal, vol. XLII (April 1946), p. 46.
[47] Saunders, ibid., p. 46.
[48] Annual Report of the Director General of Health, 1946, pp. 14–15.

Free dental service is provided to preschool and primary school children, and in 1946 free service was extended to adolescents, gradually to be extended up to age 19. During 1945, 210,920 children were treated, of whom less than 25,000 were of preschool age.[50] The total number of operations was over one and one half millions, of which over one million were fillings. The immediate goal is the service every 6 months of every person in the Dominion up to the age of 19. Post school young people will be served by private practitioners on a free-for-service basis until sufficient dental officers can be secured for the service. To facilitate the recruiting of dentists, the dental service is offering bursaries (scholarships) to dental students at the University of Otago; students agree to accept public appointments after graduation for designated periods, varying with the amount of bursaries received. In 1946 there were some 76 students in the dental school on state bursaries.[51]

It is unusual for a profession to permit persons less fully trained to practice any part of their art without viewing with alarm or protest. In this regard the New Zealand dental profession is indeed remarkable, for a state service has been developed that soon will cover nearly one third of the population of the country, and a large share of that service is carried out by dental nurses. One of the reasons for this situation may be the extraordinary need for preventive work in the dental field. Another factor may be that dentists are fully occupied with all the work that they can do. It may be due in part to the excellent leadership of the state dental service, which has never advanced too far ahead of the thinking of the profession to fall into conflict with it.

In any case the expansion of the service has been attended by the good wishes and active support of the overwhelming majority in the profession. The gazetting of regulations governing the extension of the service to age 19 might have been an occasion for conflict between the profession and the Government, but there seemed to be agreement as to necessity for increased coverage, scale of fees for private practitioners in the transitional period, and ultimate conduct by salaried dental officers.

Surprisingly little is known about the reasons for defective teeth. A dental research committee has been established under the Medical Research Council, and may produce, in the future, some significant light upon a very dark subject. The nutrition research committee under the Council has already published several studies that have an important bearing on tooth disease. Much of the responsibility for poor teeth is traced to faulty diet, but any considerable advance in this field must wait for the lessons of health education to penetrate the public consciousness and for other Government agencies to cooperate by making the right sort of foodstuffs available at reasonable prices.

APPRAISAL OF THE NEW ZEALAND PLAN

Coming to power in 1935, the Labor Government proceeded to introduce legislation to carry into force the various planks of its platform. Among the matters on which it assumed it had a popular mandate was the provision of a national health service, including free medical, dental, hospital, and other care.

Planning.—In order to implement this promise, the Minister of Health, in July 1936, appointed a National Health Insurance Investigation Committee to investigate the matter of providing medical and other treatment services. Although it held hearings through the country and collected the views of many interested persons, it cannot be regarded as an impartial and representative board of inquiry. This is the sort of task that traditionally has been performed by a Royal Commission in all British countries. Such a commission might have included top representatives of the medical profession and outstanding laymen from various walks of life. Its hearings would have commanded more widespread respect and attention than could those of a departmental committee, and service on the commission might have informed and modified the views of the leaders of the BMA.

---

[49] Editorial, New Zealand Dental Journal, vol. XL (July 1944), p. 60.
[50] Annual Report of the Director General of Health, 1946, p. 26.
[51] Saunders, op. cit., pp. 51–52.

Among the witnesses who appeared before the committee were representatives of the BMA, who presented a plan which was limited in its coverage and at variance with the Government's determination to introduce a universal scheme. The profession and the Government could not reach agreement on a common plan, and the blame for the impasse belongs in part to each. The profession probably was not consulted as fully and frankly as it had a right to expect. On the other hand, the profession was unyielding and, despite the timely warning of Dean Hercus, did not keep in close touch with the development of the Government's plan. The profession was uncompromising when faced with a Government which supported unwaveringly a universal scheme.

Launching.—Before enacting legislation for a general social-security scheme, of which health benefits were to be a part, the Government moved in the House of Representatives to create a select National Health and Superannuation Committee which was composed of both Government and opposition members. The committee received from the Prime Minister detailed proposals regarding social security, and confined its work largely to reviewing and approving the Government's plan. Further hearings were conducted, but heavy reliance was placed upon the work of the McMillan committee. Under the rules of the House, no minority report by opposition members of the committee was permitted, so the criticisms of the scheme had to be presented orally to Parliament and country.

The Social Security Act of 1938, which contained the health-benefit provisions, was passed by the large majority which Labor then held in Parliament. When the capitation scheme of compensating general practitioners was placed in operation in March 1941, the great majority of the profession refused to participate. In order to get medical benefits functioning, the Government instituted, in November 1941, a fee-for-service plan. While the BMA was willing to have its members practice under the new plan, it urged them not to collect fees directly from the state fund, but to leave collection to the patient. This "refund" method appealed to the BMA because it kept direct Government intervention out of the doctor-patient relationship.

Operation.—The first phase of the health program, maternity benefits, which were commenced in May 1939, are now generally accepted by the profession and enjoy a large measure of public support. Concerning medical benefits, it is obvious that the capitation scheme will not be generally used by the profession so long as fee-for-service exists side by side with it. The latter assures the practitioner of compensation roughly proportionate to services rendered; capitation imposes upon the doctor the indefinite obligation to provide all attendances required by the persons on his panel. Although the Government may still look upon the capitation system with nostalgic interest, the profession certainly would resist its reinstitution as the sole scheme of remuneration under the act.

Under fee-for-service, the direct-claim plan has many advantages over the refund plan. The State, under direct claim, is relieved of unnecessary administrative expenses and a heavy burden of paper work. The patient is spared the nuisance of filling out forms, which he often does incorrectly, and delay in securing payment from the social security fund. The refund scheme is favored by the BMA, but it is difficult to see much validity in the argument that direct claim interferes with the doctor-patient relationship. The limited use of salaried medical officers in remote areas is certainly defensible.

Although the leaders of the organized medical profession persist in their emphasis upon abuses that have emerged in the operation of medical benefits, such as overvisitation, overprescribing, irresponsible calls by the patient, and the like, there are many in the profession and the public who stress the gains, such as seeking early medical advice as a right not as charity, eliminating the barrier of expense from extra consultation and treatment, and releasing the doctor from concern over collections.

Conclusion.—Despite the controversy that attended its inception, we think that the New Zealand plan is a good start toward getting health services to all people regardless of their economic circumstances. We believe that most of the abuses and difficulties that have emerged could be remedied rather quickly if the Government and the medical profession would learn to cooperate with one another. The Government must recognize that professional men and women are entitled to an important voice in determining the conditions under which they shall work. The profession must understand that the feature of universal coverage of health services is highly popular with the people, and that the doctors will lose in the long run if they adopt uncooperative attitudes.

Finally, we think that the whole field of health benefits should be subjected to searching inquiry by a royal commission, which should be headed by a chairman recognized generally by the public as competent and impartial, and on which the medical profession should have representation. A thorough investigation is needed before further expansion of services, and might do much to bring the Government and the BMA close enough to provide the basis for real cooperation which is prerequisite to proper functioning of the scheme.

[Washington Star, January 15, 1948]

Letters to the People:

ANTI S. 545

CRITICIZES TAFT HEALTH PLAN

To the Editor of The Star:

A self-appointed consumer counsel for taxpaying patients, this writer would like to comment upon Senator Robert A. Taft's national health insurance program. The Senator summarizes his program thusly: "It attempts to provide only for those who are unable to pay for essential medical services, leaving those who are able to pay free to do as they choose with reference to obtaining medical service."

In this bitter ideological debate over national health insurance Senator Taft's veto power can dictate to taxpayers. It is his program or none. He affirms that only the indigent and underprivileged shall be the beneficiaries of Federal aid in meeting the bankrupting burdens of health hazards. This imposes a WPA national health insurance program upon taxpaying doctors and patients. Nothing could be more New Dealish than bluntly to dictate that only the indigent shall benefit by Federal planning. Definitely, Mr. Roosevelt was more subtle in his Santa Claus role and bid for the political support of those who cannot pay their way.

Senator Taft opposes "federalizing the whole undertaking and turning over this tremendous field to bureaucrats in Washington." But it will take bureaucrats or their equivalent to determine who is indigent and how long they will remain indigent. There will be many a juicy political plum in appointing those who have the power to spend this taxpayers' dole. In dictating this WPA health plan, Senator Taft forgets that most of us were not born with silver spoons in our mouths. Unkind fate may make those now solvent the exploited victims of this class-conscious health insurance program.

Senator Taft insists his program "would encourage the development of health insurance funds for persons who may wish to take advantage of such insurance and protect themselves against future occurrence of some form of catastrophic illnesses." This postulates the social sufficiency of voluntary and commercial health insurance programs. Apparently, Senator Taft believes voluntary programs meet the reasonable expectations of intelligent taxpayers for prepayable low cost, noncancellable cost-spreading self-help in meeting the rapidly rising costs of health hazards. If Senator Taft so believes, he becomes apologist for the admitted weaknesses of all voluntary health insurance. These weaknesses are lack of remedy for "protection lag" and "protection lapse."

"Protection lag" pertains to a mandatory waiting period which must elapse before the insured is eligible for promised benefits. Health insurance covering childbearing is the classical example. To prove the hazard did not exist at the time the policy was issued no insurance protection is afforded pregnancy or any of its complications during a qualifying 10-month period. But the stork often ignores this cautious penny-wise banker's decree. Many a new taxpayer is born during the regimented protection lag.

"Protection lapse" is total forfeiture of all insurance benefits for failure to pay insurance premiums on schedule. As champion of the profit system, Senator Taft convincingly may argue that such stupidity, improvidence or negligence deserves this heartbreaking penalty. Yet, unless the social conscience of the intelligent electorate demands a solvent remedy, the innocent and helpless will continue to suffer. Unlike voluntary health insurance, national health insurance dare not piously wash its hands by cynically declaring that the victims deserve their misfortune. The intelligent voter and weary taxpayer will challenge Candidate Taft with this reasonable query: How does your national health insurance program propose to remedy the protection lag and protection lapse of voluntary insurance?

But maybe Candidate Taft expects to win the presidency by playing Doctor Santa Claus to the indigent.

THOMAS MATTINGLY, M. D.

Senator DONNELL. Might I take just a further moment of the time of the committee on the matter of Louis Reed? I have not seen the transcript of yesterday's proceedings, but my impression is that when comment was made about him I indicated that I had learned from him in conference something of his position on this health insurance matter. As I said a few moments ago, I do not recall having asked him that question, and these notes do not indicate anything about him except possibly where he spoke about something being an eye opener, being impressed with the complexities of the prepayment plan. If I did indicate yesterday that I learned his opinion from him in a conference, I think I was in error in leaving such an impression.

In the second place, I think in justice to Mr. Reed it should be mentioned that, so far as I know, he has never applied for any employment with this committee. I think that is correct, though I have no absolute knowledge.

Senator SMITH. I can say I think that is correct.

Senator DONNELL. That is my best judgment and recollection, so I do not want to appear as saying that he had been an applicant here and had been turned down. And Mr. Reed, I may say, impresses me as a gentleman of extremely wide experience, and I have no doubt he is a man of excellent and practical experience in this work on medical service plans. Obviously, in just glancing at this volume, it represents a tremendous amount of work.

Senator SMITH. I would like to say in Mr. Reed's behalf that his name was called to my attention among a number of others as persons who might be available for a job, and I asked him to come to see me and talk it over. I was very much impressed with him, and I concur in Senator Donnell's statement. He made a good, frank statement of the whole thing. Mr. Reed was not turned down. It was just a question between the different persons we conferred with as to who we thought was the best qualified, and we selected Mr. Sneed, who is now serving us in that capacity.

Now, Dr. Shearon, we will be glad to hear you this morning, and I hope in your testimony you will make perfectly clear what your relations have been to our committee, and your interest in this subject. We want to get the relationship correctly. You have been charged with having done various things, and of course you have very decided views on the whole matter, which we have had the benefit of, and we want to get the record perfectly clear just where you stand and how you have been associated with the committee. Now, will you proceed, please?

STATEMENT OF MARJORIE SHEARON, Ph. D., DIRECTOR OF THE SHEARON MEDICAL LEGISLATIVE SERVICE, WASHINGTON, D. C.

Dr. SHEARON. Thank you, Mr. Chairman. I myself have felt that I should be a little more detailed in regard to my professional qualifications than I have carried in the beginning of the paper here, where I have dwelt at length on my professional qualifications.

As to the charges that have been made against me, I feel that this rostrum is not the place to answer those charges. I am here as a professional consultant in the field of social security and health insurance legislation. I came here to help the committee, all members of the committee, and that is what I want to do, what I want to talk about, nothing about myself personally. My own record stands for itself.

Senator MURRAY. Do you intend to go into the connections that you have had with the committee?

Dr. SHEARON. Yes. In the first two or three pages I give that, Senator. I think it will be entirely full, and if not I will be glad to answer questions.

I have been asked by this subcommittee to appear as the final witness at these hearings. I appreciate the opportunity and am aware of the responsibility which devolves upon me.

For the record I may state that I am director of the Shearon Medical Legislative Service, author and editor of American Medicine and the Political Scene—a weekly analytical news release—writer, lecturer, and legislative consultant. My academic training was in scientific research in the biological sciences. I received my Ph. D. degree in science at Columbia University in 1916. For 10 years I was engaged in research in pure science and in college and university teaching. I have published extensively in scientific journals and am a past fellow of three national scientific societies. For the past 15 years I have been engaged in public administration, Federal, State, and local. My recent experience includes nearly a decade in the Executive branch of the Federal Government, 5 years in the Bureau of Research and Statistics of the Social Security Administration, and 4 years with the United States Public Health Service. From February 1945 to March 1947, I was research analyst first to the minority conference and later to the majority conference of the Senate. Last year I served for a time as health consultant to the Senate Committee on Labor and Public Welfare, later becoming a part-time consultant to Senator Robert A. Taft. That is the period from July 1 to December 31, 1947. He was at that time, of course, chairman of the Committee on Labor and Public Welfare. Presently I am operating my own business and am not in the pay of any individual or organization. I have no political, business, or professional ties, nor am I a member of any political party. As a legislative consultant, I appear in the public interest, expressing my own views but not speaking for any group or special interest.

Senator MURRAY. Before you go any further, I would like to ask you, Dr. Shearon, you say in your statement that from February 1945 to March 1947 you were research analyst, first to the minority conference and later to the majority conference of the Senate.

Dr. SHEARON. Correct.

Senator MURRAY. Were you on the pay roll of the Senate?

Dr. SHEARON. No; I was not. My salary was paid by the Republican National Committee. That has a very terrible sound for a research person, and I hesitated a long time whether I would consider that type of job, because I did not want to have a connection with any political organization. I am not a Republican, and Senator Taft knew that. He was interested in getting a qualified person to advise him on this legislation.

I was paid by the Republican National Committee, but I was assigned down here. And I may say that throughout my entire connection with the minority and the majority, and also with Senator Taft as part-time consultant, I never submitted any statement of mine to either Senator Taft or any of the Republicans, or to the Republican National Committee, as to clearance on policy. I mean I wrote as a research person, giving my own views, and everything I have put out carried a little statement at the bottom that I was expressing my own views, and I was perfectly at liberty to say, for instance, that a Republican bill was not a good bill. They wanted my expert advice, and at this point I would like to express my very great appreciation to the Republicans for their kindness and consideration to a person who is not a Republican. I am not affiliated with any party. I have never been enrolled in any party. In fact, I never was interested in politics, but if I had been pinned down to it 10 years ago to say which camp I was in, I would have said the Democratic, although I was not enrolled. But the point I want to make is that I did not clear anything for policy. It was understood that I would be given free rein as a research person, so that while my salary was paid by the Republican National Committee, I was assigned down here; I had a room down here in the Senate Office Building and did not have a room up there at the Republican headquarters. I had nothing to do with them except to get my pay check from them twice a month.

Senator MURRAY. But you were not on any pay roll of the Senate?

Dr. SHEARON. I was not on the pay roll of the Senate, that is correct, until last March. From March then until the end of June I was actually on the Senate pay roll.

Senator MURRAY. How was it arranged for you to be on the pay roll of the National Republican Committee? Who arranged that?

Dr. SHEARON. Well, after I left the Public Health Service January 1945 I went to see a man whom I knew in New York, Virgil Jordan, the president of the National Industrial Conference Board, and I presented my qualifications. I had resigned and had no job. I just resigned and left. So I told him my qualifications and he said, "We could put you on our staff," and I said, "Well, I think I belong in Washington because of my qualifications" and he said, "Senator Taft is looking for someone like you with your qualifications. Why don't you see him?"

I said, "I don't know him; I don't know any politicians. I always thought as a research person I didn't want to know any politicians." I prided myself I had no political ties whatever. I said, "Furthermore, I am not a Republican." He said, "You go to see him." He referred me to George Smith who was the secretary to the Minority Conference, and I came down and showed him my credentials and he made the appointment with Senator Taft who in turn spoke to Mr. Brownell about using the political funds that way for research.

They have their own research organization at the Republican National Committee under Dr. McCaffree, and eventually I was placed on his staff and was assigned right down here.

The only Senators I knew were Democratic Senators. This is the way I came to know them: I think you may recall back in 1941 when Senator Downey asked me to come down and serve as a consultant on Old Age Insurance. At that time I met Senators Downey, yourself, and Senator Pepper. They were the ones I remember best of all because I worked most closely with them. I don't think I knew any Republican Senators.

Senator Murray. As between politicians you paid no attention to whether or not they were Democrats or Republicans?

Dr. Shearon. That's correct.

Senator Murray. You had just as much regard and respect for me as you did for Senator Taft?

Dr. Shearon. That is perfectly true, Senator. You have had a bad misunderstanding. If you and I were to get together for a half hour we would fix everything up okay. As a matter of fact, we had a very pleasant talk for three-quarters of an hour after I came on the committee. You said you didn't want to object to me on political grounds.

Senator Murray. I was very sorry we had any misunderstandings.

Dr. Shearon. I too am sorry.

Senator Murray. I thought we should have got along a little better, but isn't it a fact that you were sending out circulars and statements around the country during the time that you were here?

Dr. Shearon. No. I stopped while I was with the Senate committee. I simply discontinued my publications and then I went off the Senate committee pay roll on the 30th of June and opened my office the next day. I then started up my publications again. I was very punctilious about that, Senator.

Senator Murray. You didn't start up these circulars and publications of propaganda until after you had left?

Dr. Shearon. The Senate committee, that's right.

Senator Murray. I haven't got the papers here.

Dr. Shearon. I think the thing you have in mind, Senator, was the announcements I sent out in June about establishing my business. After all, I am entirely dependent upon my salary and I have financial obligations. I was fired rather suddenly and with no job in sight. So in June I announced that I was going to open an office when I left the Senate committee, but I wasn't sending out releases or speeches or anything like that. As a matter of fact, I was very busy on the Hill hearings.

Senator Murray. When did you prepare that Blueprint?

Dr. Shearon. The Blueprint was prepared entirely before I came to the committee. As a matter of fact, it was a speech the year before back in 1946 I gave in Chicago and it was published—the first printing was in January of 1947. It was sold out before it came off the press. I had a second printing immediately and then the third printing. As a matter of fact, I think the date is probably on it.

Senator Murray. Yes, it is. You said before——

Dr. Shearon. Before I came.

Senator Murray. That was before you became a research analyst for the minority conference?

Dr. Shearon. No, before I came to the Senate committee. The first printing was in January 1947, the second was in February 1947 and then the third printing was after I left, and that was in July 1947 after I left the committee.

Senator MURRAY. Well, you recall I didn't think very much of that Blueprint.

Dr. SHEARON. Well, Senator, I am glad you mentioned that. You referred to this and I would like to clear this up now while we are at it. We might as well clear up a number of things.

You referred to this little photostat of which there were to the best of my recollection about 14 copies. They were never circulated, and this was very much discussed, including the word "fellow-travelers."

As I have explained, or rather as Senator Donnell explained after consulting me, I was using this expression and the whole chart in itself conveys that idea—"fellow-travelers" with Falk. Then I showed this to an editor and he said that expression could be misunderstood. I said, "Oh, I don't think so." He said, "Well, it could. You had better leave it off when you print it," so I did leave it off, and you will note that on none of my printed charts does this—Have you a copy, Senator?

Senator DONNELL. Yes, I have one.

Dr. SHEARON. You will see on the heading there it doesn't say "fellow-travelers" and it does not on any of the editions, and that is a part of the record.

And I might say this also: If you would like for the record, Senator, I wrote up this summer a little typewritten statement for Senator Donnell in regard to the history of this chart, and it was simply a chart. I hadn't even written my speech at the time I did the chart. The evolution of this thing goes back to my having given a speech. I had no notes or anything and gave a speech with a very rough little diagram. I have the whole series of charts, and this was one of the intermediate stages.

Senator DONNELL. By "this" you mean the photostatic copy?

Dr. SHEARON. This photostatic copy that you have in your hand, Senator Murray. I had this with me at the time that I gave a speech in Chicago. It was a mimeographed speech and it didn't have any copy of this chart.

This is a photostatic copy. I couldn't afford to make very many copies of it. I just had one copy on the table and somebody—I don't know who—came up and asked me some questions and while I was answering I turned to somebody else and the next thing I knew the chart was gone. That is the only way I can imagine it could ever get into circulation because it wasn't circulated, so your thought that that chart had gone all over the country with that title is entirely incorrect.

Senator MURRAY. Well, it not only referred to these people that are connected with this proposed legislation as "fellow-travelers"——

Dr. SHEARON. With Falk.

Senator MURRAY. It reads as follows: "Spheres of influence and interlocking directorates." You start off by undertaking to insinuate that Dr. Falk of the Social Security Administration is solely responsible for this proposed legislation.

Dr. SHEARON. Well, isn't he?

Senator MURRAY. And we sponsors of the legislation are mere "fellow-travelers and collaborationists, appeasers, satellites, and gullible acceptors."

Dr. SHEARON. Pardon me, Senator, but I didn't identify in which classification the people on this chart appeared. I thought I would let them decide.

Senator MURRAY. Let them decide for themselves. I see.

Dr. SHEARON. That is correct. That is really the case.

Senator MURRAY. Well you see——

Dr. SHEARON. You see here indirect lines of control I have down here, the dotted lines at the bottom of the chart. I think that is the same on the chart you are holding in your hand.

Senator MURRAY. We are connected right up with this.

Dr. SHEARON. That's right.

Senator MURRAY. You have these dotted lines and it points up here to the Congress of the United States and you have Congressman Biemiller and Congressman Dingell and Senator Wagner and Senator Murray and Senator Pepper all as a part of this scheme or program which is being used, and that we are nothing but collaborationists and fellow-travelers, appeasers, statellites, and gullible acceptors. I thought that was not a fair statement for you to make.

Dr. SHEARON. Well, Senator——

Senator DONNELL. Pardon me, Senator, are you reading now from the photostatic copy?

Senator MURRAY. Yes. You have prepared this?

Dr. SHEARON. Oh, certainly, it's entirely my own work.

Senator MURRAY. And you used this at the time you were making that public speech?

Dr. SHEARON. Yes, that's correct.

Senator MURRAY. And you sent out other literature besides this, of course, in which you referred to the sponsors of this legislation as being fellow-travelers?

Dr. SHEARON. I don't think you will find that in anything. I know you won't because, Senator Murray, I don't think you are a Communist or a fellow-traveler, and I don't think anybody else thinks so. It's perfectly obvious.

(The chart under discussion appears on p. 2804 in the Appendix, this volume; a memorandum pertaining thereto, by Senator Donnell, appears on p. 2803.)

Senator MURRAY. I am glad to have you make that admission here.

Dr. SHEARON. There's no admission. It would be common knowledge, would it not? It was farthest from my thought that you are a Communist. As a matter of fact, I do not think any of the Government people who are working in this field are Communists. I think many of them are fellow-travelers, but certainly you can't say they have got a Communist card.

Senator MURRAY. You wouldn't class me as a fellow-traveler only?

Dr. SHEARON. With Falk only.

Senator MURRAY. You say I am under the influence and dominance of Mr. Falk and that I am a fellow-traveler being used by Dr. Falk for the purpose of sponsoring this legislation? Is that your idea?

Dr. SHEARON. I think that would be pretty correct, wouldn't it, Senator?

Senator MURRAY. I think that is a complete falsification of the facts and I think if you tried to pretend that you are impartial in this matter and you are nothing but a research analyst, why I think that is absolutely going to an extreme that can't be justified by any facts that you can present.

Dr. SHEARON. Well, Senator, he did write the legislation inside the Federal Government and did hand it ready-made to you.

Senator MURRAY. Oh, no, oh, no. No, I came into this legislation as a member of the committee. The original bill by Senator Wagner was before the committee and I was a member of the committee. I didn't know Dr. Falk at that time. I didn't know anybody connected with the Social Security Administration. Accidentally I was placed on a subcommittee to conduct the hearings. During those hearings I was on extremely friendly terms with the doctors who appeared there.

Dr. SHEARON. Yes, that's right.

Senator MURRAY. They came to me and asked me for assistance and permission to present their witnesses, and I told them that anything they wanted they could have.

Dr. SHEARON. That's right.

Senator MURRAY. And everything was conducted in a very satisfactory manner. I didn't know Dr. Falk at that time. I had never seen him.

Dr. SHEARON. He had written that bill that you came in on. You see, you sort of inherited it from Senator Wagner.

Senator MURRAY. No. The bill that I came in on I never saw Dr. Falk in connection with.

Dr. SHEARON. No. Senator Wagner sponsored it—that was the one we were dealing with then—Senator Wagner, when we wrote the '39 bill in the Social Security Board.

Senator MURRAY. Well, when the next bill came in?

Dr. SHEARON. The '43 bill.

Senator MURRAY. I was in Senator Wagner's office and went over it with him and we had the assistance also of congressional experts here, legislative experts, and at no time had I consulted or talked to Dr. Falk in connection with that bill, so for you to set out a chart like this in which you make it appear that I am just a tool or fellow-traveler with Dr. Falk is utterly unfair. In fact, it was a falsehood to make such a statement as that.

Dr. SHEARON. Well, Senator, after all, the bills were written in the Social Security Board and they were handed over to you and the 1943 drafts, before their introduction by you and by Senator Wagner and Congressman Dingell were very much the same as the bill when introduced. Of course there were slight changes, but the bill was essentially the same as written in the Board.

I mean the 1943 bill as it came out full-blown in print. I have the full history of the '43 bill. As a matter of fact, I was in on it for months.

Senator MURRAY. I don't know where you got your history; not from me.

Dr. SHEARON. I was with Dr. Parran at that time.

Senator MURRAY. Coming back to this Blueprint, during the period you were on the pay roll here you received orders for this Blueprint, did you not? You sold it to different people in the country?

Dr. SHEARON. Yes; certainly.

Senator DONNELL. You mean on the pay roll of the Senate, Senator?

Senator MURRAY. On the pay roll of the Senate.

Senator SMITH. Those were later printings. I recall this; that I had a talk with Dr. Shearon and she will remember this. I thought it wouldn't appear appropriate for Dr. Shearon in any way to be reflecting on any member of this committee. She agreed with this and discontinued all of her previous activities at our request, and then, Senator Murray, when you protested you remember the meeting we had, we asked Dr. Shearon to resign as of June 30 because we didn't want any questions as to her qualifications for the job, and even any suggestions that she was unfairly handling our advisory work for us. We did that because you requested it.

Senator MURRAY. That was because we found additional evidence of her continued activities.

Senator SMITH. I think this book probably was printed further because of demand. Now that might have some criticism. I think it was going pretty far where this was printed earlier to discredit Dr. Shearon for having a third printing because of the demand of people for it.

Senator DONNELL. What was the period in which you were on the pay roll of the Senate?

Dr. SHEARON. It was from March—I think it was March 23.

Senator DONNELL. 1947?

Dr. SHEARON. 1947, to June 30, 1947.

Senator MURRAY. Well, you did sell copies of the Blueprint?

Dr. SHEARON. Well, I think if I had any left—the edition was nearly exhausted and I didn't have another printing made until July, after I left the employ of the committee. If there were any copies left and I had any requests, I sold them, yes; or gave them away. I gave away a great many.

Senator MURRAY. Well, then after this discussion had come up with reference to your lack of impartiality, you made a speech before the West Virginia Medical Society, didn't you?

Dr. SHEARON. No; Senator Murray, that was before that discussion. That was—well, I could supply the date. It was early in——

Senator MURRAY. Have you a copy of that speech?

Dr. SHEARON. I have a copy of it and I would be very glad to supply it.

(The address referred to is as follows:)

BUREAUCRATIC CONTROL OF MEDICINE[1]

(By Marjorie Shearon, Ph. D., consultant, Senate Committee on Labor and Public Welfare, Washington, D. C.[2])

Tonight you have come together to celebrate the eightieth anniversary of your State medical society. You have had occasion to recall with pride the notable advances made in medicine during these 80 years. One month from tonight your parent organization, the American Medical Association, will celebrate a century of achievement. Probably few persons would challenge the statement that the United States today stands preeminent in the field of medicine. Standards of medical education, outstanding contributions in medical research, and easy availability of health and medical services to the major portion of the population place the United States in a unique position among the countries of the earth. We have more physicians per unit of population than any other country in the world. Our health indices for comparable population units are not surpassed by those of any other country.

In the face of these facts, how can we account for the persistent efforts which are being made to destroy the American system of medical education, medical research, and medical practice? What justification can be found for the propaganda which has flooded the country, especially during the past decade, in support of a revolutionary upheaval in the entire system of American medicine? What is offered in lieu of what we have?

---

[1] Presented before the eightieth annual meeting of the West Virginia State Medical Association at Charleston, May 12, 1947.

[2] The views expressed are those of the writer and not necessarily those of any member of the Senate Committee on Labor and Public Welfare.

These questions are not difficult to answer. First of all, we are asked to exchange freedom of action by patients, physicians, and institutions for the despotism of bureaucracy. Secondly, we are asked to adopt an old-world system of government medicine which is not known to have succeeded anywhere, but which nonetheless is loudly acclaimed by those who would gain power were such a system established in this country. Thirdly, justification for this proposed revolution is found in the purposely misleading "research" documents which are disseminated by governmental and nongovernmental lobbies with a view to shaping the opinions of Congress and of the public in favor of a medical system controlled and financed by the Federal Government.

How has such a situation come about? Are the politicians to blame? Not directly, for they are not the planners and prime movers. I believe the danger lies not in political, but in bureaucratic medicine. The two are not synonymous. Neither the President nor any Member of Congress has the time or the professional competence to draft the complex legislation dealing with Government control of medicine. A politician could not, if he would, write rules and regulations for administration of a comprehensive national health program. It was not politicians who initiated the lobby for nationalization of medicine. It was not politicians who drafted the blueprint. Instead, it was a small group of Federal officials who made the plans, wrote the legislation, supervised the lobbies, issued the publicity, and made elaborate studies of the rules and regulations in foreign countries preparatory to drafting similar administrative regulations for the United States.

There are those who, oblivious of the signs of the times or perhaps secretly in favor of them, will tell you that all is well and that there is nothing to fear. The nationalizers encourage this feeling of complacency even as Hitler duped Chamberlain. It is ever easier to be unalarmed than it is to face painful realities requiring action. I realize that the enactment of Federal legislation for national compulsory sickness insurance is not a threat this year. But I call your attention to the fact that within the Government at Washington propaganda for compulsory sickness insurance still is going on. Private lobbies still are active. Nor can we forget that compulsory legislation has been enacted in other countries not because of popular demand or even with the consent of the people, but as a result of the activities of small, well-organized groups, all of which are following the same international blueprint.

We have before us the example of Great Britain where, since enactment of the national social insurance law of 1911, medicine has felt increasingly the heavy hand of bureaucratic control. It takes several decades for the destructive processes inherent in national social insurance fully to be felt. It takes more than one generation of physicians reared in an environment of regulative interference for the profession to feel the complete effect of government domination of medical education, research, and practice.

Some years ago the Lord Chief Justice of England wrote a book entitled "The New Despotism." He described the administrative lawlessness visible throughout the executive departments in Great Britain. Noting that it was the officials in the Government departments who initiated the legislation by which arbitrary powers were conferred upon them, he said:

"Arbitrary power is certain in the long run to become tyranny, and there is danger, if the so-called method of administrative 'law', which is essentially lawlessness, is greatly extended, of the loss of all those hardly won liberties which it has taken centuries to establish." [3]

In discussing the mischiefs of bureaucracy he pointed out that the excellence of the civil service might actually work against the public interest to a greater degree than a bureaucracy of less able experts. For, as the Lord Chief Justice pointed out, "* * * It may perhaps be well to remember that high capacity and ardent zeal need to be more carefully watched than when they appear to have entered with all their might upon a wrong road. It does not take a horticulturist to perceive that, if a tree is bearing bad fruit, the more vigorously it yields, the greater will be the harvest of mischief."

Lord Hewart warned that "if there were any great extension of the system of giving uncontrolled and arbitrary powers to public officials, it is as certain as that night follows day that corruption must creep in. We shall then be cursed with the corrupt bureaucrat. The bureaucratic despot we already have."

---

[3] Lord Hewart of Bury, The New Despotism, New York, 1929, p. 52.

To illustrate his point, Lord Hewart said: "The treatment of the panel doctors under the national health-insurance acts is pure despotism. The doctors are liable, at the mere discretion of the official who acts for the Minister of Health, to be ruined professionally by being struck off the panel, or, as a lesser punishment, to be fined to an arbitrary extent. In one instance, a fine of £1,000 was imposed on two doctors who carried on business in partnership. 'Excessive prescribing,' an offense wholly unknown to the law, which consists in prescribing for the patient medicines that are either too expensive in quality or too liberal in quantity, is one of the things for which a doctor may be penalized. One might think that, for a person who is bound by law to insure and pay contributions under the [health insurance] acts, the best medicine ought to be prescribed in illness. One might also wonder whether, in this matter, the interests of the patients are taken into consideration at all." [4]

It has been well pointed out by an Australian that "there is no penalty for underprescribing, no penalty for undercertification, no penalty for undertreatment—a cynical disregard of the welfare of the patient, which is further illustration of the fact that the Government's interest in the whole matter is purely financial." [5]

The rules and regulations for compulsory sickness benefits are well established, and if a Wagner-Murray-Dingell bill were to be enacted in this country I surmise that the administrative regulations would not deviate to any great extent from those which have been developed in other countries. The problems of health insurance administration have been wrestled with for upwards of 65 years in different parts of the world. Human ingenuity in over 30 countries has had the fullest opportunity to discover workable methods, if there are any. No country has even approached a satisfactory solution to the problems. Administration becomes more cumbersome each year. Sickness and vagaries of human nature refuse to be neatly pigeonholed. By the time the British scheme had been in operation 20 years, there were over 2,000 regulations in force to plague physician and patient alike. Before three decades had passed it required a volume of nearly 1,300 pages in length to cover the basic health-insurance laws and amendments thereto, the Government rules and regulations, the official interpretations thereof.[6]

It is obvious that if the Federal Government is to pay for medical care, for hospital services, for prescriptions, for nursing, dental, X-ray, laboratory, and a host of other services, the Government must define the services. If it attempts to pay a physician on a fee-for-service basis, it must pay specified amounts for a given number of minutes of a physician's time and must allow for overtime. The administrative difficulties of fee-for-service are so insuperable that no person familiar with them believes the Government could or would operate on that basis. Indeed, one of the leading advocates of compulsory sickness insurance, Dr. Ernst F. Boas, chairman of the Physicians Forum, Inc., has frankly stated: "Insurance guaranteeing complete medical coverage cannot be set up except at a prohibitive cost, if the fee-for-service principle is retained." [7]

If the capitation system is adopted, the physician holds the bag. The Government makes the promises; the physicians carry them out. However unreasonable the promises may be, the physician must somehow contrive to fulfill them if he agrees to become an insurance practitioner. He must contract to accept some nominal amount, say $5, $6, or $7 a year (it is $2.25 in Great Britain) for each person on his list. He must give to those patients all the services they demand and the Government promises. In other relationships in life when a contract is made both contractors know in advance what is being agreed to. But when a doctor makes a contract with the Government under compulsory sickness insurance he is making a blind date with fate. The Government can and does change the rules of the game whenever it sees fit. It can redefine services; it can lower capitation rates; it can tell a physician when he may or may not send a patient to a hospital; it can call a physician on the carpet for "overprescribing"; it can issue punitive regulations and can fine physicians for infringements of the endless regulations which must be issued in the vain attempt to regularize medical practice.

The administrative patterns of bureaucratic medicine follow the same general plan in all countries. Federal officials in Washington have for years been studying the classic volumes on administration published by the International Labor Organization and by the governments of foreign countries. The basic text is the volume entitled "Economical Administration of Health Insurance Benefits," which was published at Geneva by the ILO in 1938. The first part is devoted to a lengthy discussion of the principle of economy in administration, the second to the principle of economy in national laws and regulations, the two together requiring some 300 pages.[8] The volume is replete with statements and statutory provisions designed to curb the freedom of action of physicians and patients. Economy of administration is the watchword of insurance medical practice. You will note the frequent inclusion of the "economy" principle in the Wagner-Murray-Dingell bills. The insurance practitioner at every turn must say to himself, "Which of these two procedures or drugs is the cheaper; which will save the insurance funds," instead of saying, "Which is better; which will save the patient." He must be ever mindful of the funds, ever subservient to the Federal insurance inspector, ever on the defensive to justify his professional decisions and to defend himself against charges of real or fancied infringements of Government regulations.

---

[4] Ibid., p. 50.
[5] Byrne, Charles, Proposals for the Future of Medical Practice, Melbourne, 1943, p. 115.
[6] Lesser, Henry, The Law of National Health Insurance, London, 1939, 1281 pp.
[7] Boas, Ernst F., Why Do We Need Health Insurance? No date, p. 13.

To illustrate a general principle regarding doctor-patient relationship under Government insurance practice, I quote from the ILO text to which I just referred. In the chapter devoted to "the application of the principle of economy to diagnosis," there appears this statement:

"If a private practitioner recommends some necessary form of a diagnosis to his patient and the patient declines to have it, either because it is physically repugnant to him or because he finds it too expensive, the doctor can, if his professional conscience permits, console himself with the thought that he has given the best possible advice. The insurance practitioner, on the other hand, must urge the insured person to follow his advice as regards diagnosis. If the patient still objects, the doctor must consult the medical adviser of the insurance institution or send his patient to a hospital, because otherwise the necessary measures for diagnosis, prevention, or cure will be applied without sufficient preparation and will therefore not be truly economical." [9]

In carrying out this principle of economy the law in Germany required that "The attending practitioner must prove the necessity of hospital treatment in writing." "Economical treatment" was defined in the law, and the practitioner was adjured in carrying out his duties to save the fund expense as far as the nature of his services permits. The Government inspectors and tribunals were the final arbiters as to whether or not a physician had been sufficiently solicitous of the insurance funds.

Since an insurance practioner is liable for losses incurred by the insurance fund if he fails to compel the patient to follow his advice, and since he may be haled before a tribunal to defend subsequent demands on the insurance fund in the event that a headstrong patient adopts a course which later leads to expensive treatment costs, the practitioner in Germany is authorized by law to send a patient to the hospital without the patient's consent. The law states: "The consent of the sickness fund must be obtained before admission to hospital except in urgent cases." The patient's consent is not required if, inter alia, "the patient repeatedly disregards the doctor's instructions or the rules for the conduct of patients." [10]

With respect to prescribing by insurance practitioners, we find these principles and rules enunciated for the German scheme:

"The sickness fund has to prepare data enabling the Insurance Practioners Association to control excessive prescribing by means of the standard cost of prescribing. For this purpose the cost of prescriptions per case is calculated for groups of practitioners and for each individual practitioner.

"The IPA also checks the cost of prescribing medicines and minor appliances. If this cost exceeds the so-called standard cost of prescribing, the doctor can be made liable for part of the excess.

"The standard cost of prescribing is fixed in a national agreement between the IPA and the central federations of sickness funds of March 18, 1938, and represents the average amount per case treated, which as a rule is not exceeded in the economical prescription of drugs and appliances.[11]

Under insurance practice the Federal policing of the system would be accomplished through a special medical supervisory department under the direction of a chief medical referee, if the usual pattern were followed. In Germany there was 1 full-time medical referee for every 25,000 insured persons. In the United States that would mean an army of 5,600 Federal medical referees to police the system. In each district office there would be supervisory committees and subcommittees for special questions. In addition, there are pricing bureaus to check individual prescriptions. There would be about 700 pricing bureaus in the United States, and these would cooperate with the accounting officers of the Insurance Practitioners Association.

---

[8] Economical Administration of Health Insurance Benefits, ILO, Geneva, 1938, 332 pp., p. 197.

[9] Ibid., p. 38.

[10] Ibid., p. 197.

[11] Ibid., pp. 208, 209.

In policing the insurance system to assure that all practitioners are abiding by the economy principle, which is the sine qua non of insurance practice, the IPA accounting office keeps statistics on the number of cases treated by each general practitioner and specialist and on the number and cost of prescriptions. When the insurance fund files a claim against a physician who is suspected of overprescribing "the practitioner's average case expenditure for the quarter of the year under review" is computed. If this expenditure is in excess of the standard cost of prescribing, a claim for damages is submitted. "The standard cost of prescribing per case treated is fixed in the national agreement for the whole country." [12]

I have given these detailed illustrations to show a few of the ways in which American medicine would come under bureaucratic control if compulsory sickness insurance regulation were enacted. The real threat lies not so much in the basic law but in the subsequent rules and regulations which, while not enacted by Congress, would yet have the force of law. This would be the new despotism of which you have had a foretaste in the regulations issued by the Children's Bureau, the Social Security Administration, the Federal Security Agency, and the Public Health Service. However, the grants-in-aid programs of these agencies do not begin to carry such administrative powers as does a compulsory program.

If there is anyone here tonight who thinks there is little likelihood of enactment of Federal compulsory sickness insurance legislation, I ask him to look at the record of the past 10 years. Within the framework of the Social Security Administration you have seen created in the Bureau of Research and Statistics a Division of Health and Disability Studies. Such compulsory legislation as the health and medical titles of the Wagner-Murray-Dingell bills has been written in that bureau. The amount of propaganda for compulsion that has emanated from that bureau is staggering. "Research" memoranda, speeches, reports, radio addresses, and statistics are prepared in, and circulated by the bureau. Voluntary methods are damned, compulsion extolled. The opinions of welfare groups similarly are shaped. The propaganda machine works ceaselessly, on the accepted theory that if a thing is said often enough people will believe it.

During the past 20 years we have seen the strengthening of propaganda groups. There has been a studied policy of misrepresentation as to what a Federal health program would involve. The question of costs has been almost completely bypassed. I do not recall having seen any frank and open discussion of the degree of regimentation of patients, physicians, and institutions that would inevitably result. The compulsory program is seductively presented to the public and to Congress as one that would provide "the best modern medical care" with only slight changes in the organization of medical practice and at almost no additional cost. If the Federal officials who drafted the successive Wagner-Murray-Dingell bills were to reveal to the public and to Congress the true and inescapable characteristics of a compulsory scheme, I doubt if there would be any support for this type of legislation in Congress, by organized labor, or by the public at large. Only through gross misrepresentation can the scheme be sold. And it is undeniably being sold.

Last year the Railroad Unemployemnt Insurance Act was amended so that railroad employees should reecive liberal cash benefits for nonoccupational sickness and accidents and for maternity. The law which goes into effect on July 1 this year, unless the amendments are rescinded, is dangerous inasmuch as it is based on the extraordinary principle that the employer is financially responsible for nonoccupational sickness benefits. The employees do not pay taxes, but receive the benefits as a form of selective private charity deceptively called social insurance. If those benefits go into effect we may expect demands from all other groups of employees for similar charity at the expense of the employers or of the public. Nor is that all. The "free" sickness insurance benefits inevitably will be followed by public medical care, financed from general or special taxes and controlled by the Federal Government.

Last year another law was passed which may have seemed remote to you. It was an amendment to the Social Security Act giving unemployment compensation to maritime workers. At the same time an effort was being made to establish sickness insurance for the same group, the idea being to bring these workers into the social security system of the United States, and then through the ILO to agitate for cash sickness and medical-care benefits for this particular group as a prelude to similar agitation for all workers.

---

[12] Ibid., p. 209.

As most of you know, the United States became a member of the International Labor Organization in 1934, at the instance of former Labor Secretary Frances Perkins. At the same time President Roosevelt appointed a Committee on Economic Security to draft social security legislation along the lines prescribed by the ILO for member nations. The Social Security Act of August 1935 was the first tangible evidence of our national move to the left. That act followed the Socialist line. Parenthetically, I might say that the ILO principles are now nearer to communism than to socialism. How closely our legislative proposals are hewing to the ILO is indicated in the language and definitions used. For instance, some of you were concerned recently when Dr. Vane M. Hoge, Chief of the Division of Hospital Facilities in the Public Health Service, made the statement that the Hospital Construction Act reflects the current concept that public health includes responsibility for the treatment and care of the individual.[13] The ILO already had proposed in 1944 that the term "health service" shall comprise both medical and general (i. e., public) health services.[14]

In 1927 the ILO published a volume on sickness insurance laying down the principles which we are adopting one by one in this country. In 1938 it produced the volume on administration of sickness benefits to which I have already referred. In 1944 it brought the medical principles up to date in still another volume. The provisions, language, and social philosophy of the 1944 ILO report are so like the 1943 Wagner-Murray-Dingell bill that one may surmise the same person had a hand in drafting both. Here are a few of the principles selected at random. What a familiar ring they have. Thus, the cost of the combined medical care and public-health service program must "be borne collectively by all members of the community." The Communist principle of "to each according to his need, from each according to his means" is exemplified in the recommendation that each member of the community should pay into the insurance fund according to his ability and receive from the Government "comprehensive care" of "unlimited availability." The rational organization of medical-care services calls for group practice in Government-owned and operated, or Government controlled, health centers. "In Russia," so the ILO reports, "the medical care service is based on such centers." [15] The "draft schemes and plans" and the ILO "almost unanimously advocate and encourage some form of group practice at such Government centers. As to freedom of choice," the ILO states:

"The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem." [16]

Finally, I would point out that the ILO admits that, "The capitation fee system suffers from the fundamental defect that doctors receive an income inversely proportionate to the amount of work involved or given." To get around that difficulty, the ILO proposes a basic salary augmented by capitation fees, or (alternatively, a full-time salary. In 1944 the ILO stated:

"A salary system is actually in force in Chile, Peru, Costa Rica, and Russia, and its introduction is proposed in the plans of the South African Medical Association, the Parliamentary Committee on Social Security and the National Health and Medical Research Council of Australia, and the Labour Party and the Socialist Medical Association of Great Britain." [17]

The Socialist program of the ILO is slowly but surely prevailing in Great Britain. Early this month the report came from London that the national health service will start in England and Wales in about a year. Hospitals and their endowments will become the property of the state. Great Britain's 20,000 general practitioners and thousands of specialists, nurses, dentists, pharmacists, and other health personnel will be given a chance to decide whether or not they wish to become servants of the state. The medical profession has won a few weak concessions. Its original show of a united front against state control appears to have given way to a policy of appeasement. A physician no longer will have his private practice; practices will belong to the state.[18]

In the light of this steady progress of state medicine in one country after another, and in the light of our national commitment to follow the Socialist, if not the Communist, line of the ILO, I shall conclude with this question: Do you wish to adopt the plan for the nationalization of American medicine which has been developed by the Social Security Administration or do you wish to take the necessary steps to rid the Federal Government of those who are actively engaged in collaborating with foreign organizations which are working for the extension of socialism and the destruction of private enterprise, including the American system of medical practice?

---

[13] Hospitals, January 1947, p. 70.

[14] Social Security: Principles, and Problems Arising Out of the War, ILO, Geneva, 1944, Report IV (1), p. 59.

[15] Ibid., p. 74.

[16] Ibid., p. 83.

[17] Ibid., pp. 89, 90.

[18] New York Herald Tribune, May 4, 1947, sec. 1, p. 22.

Senator MURRAY. I would like to have the committee have a copy of that speech and the date. Give me the date.

Dr. SHEARON. Yes; the date was early in March. I think it was perhaps about a couple weeks before I was appointed to the committee.

(Dr. Shearon subsequently stated for the record that its delivery, on May 12, was later in point of time than she had recalled, but antedated Senator Murray's request that no further pertinent speeches be made by the consultant.)

Senator MURRAY. This was while you were research analyst for the Minority Conference?

Dr. SHEARON. That's right. I asked Senator Taft if I might give the speech. He didn't see it beforehand. He said okay, and I went. But he didn't see the speech at all. I never cleared any of my speeches with him. I simply got permission to go.

I might say the reason I know that I didn't make that speech while I was on the committee after the agreement is this. I also several months before that time had agreed to speak in Omaha, the Health and Accident Insurance Underwriters Conference. I had my train reservations and hotel reservations all made, and I was to have spoken I think the week after I was appointed to this position with the committee.

Senator MURRAY. With the committee.

Dr. SHEARON. But after my conversation with you, Senator Smith, and you, Senator Donnell, I think you may recall I said, "Well, I have a previous commitment on this speech." I said Senator Taft had okayed my going. I said, "I have never canceled a speech just before a meeting. I don't like to do that."

You said you had agreed with Senator Murray I shouldn't speak any more, and so I canceled that speech. I returned my tickets and canceled the whole business, even though my name was on the program, so I can assure you, Senator Murray, that I most punctiliously didn't do any speaking while I was on the committee after you objected on May 22, 1947.

Senator MURRAY. While you were with the Minority Conference. When you say Minority Conference, you mean the Republican Minority which became the majority later on?

Dr. SHEARON. That's right.

Senator MURRAY. And you continued to serve after they became the Majority Conference?

Dr. SHEARON. That's right.

Senator MURRAY. In your statement here you referred to it as the Minority Conference—the Minority Conference part of the time.

Dr. SHEARON. I said, "and later to the Majority."

Senator MURRAY. "And later to the Majority," that's right. Well, now during the time that you were serving as a research analyst on that conference, you were making these speeches and getting out these charts and plats and so forth.

Dr. SHEARON. Well, yes; I made very few speeches, but I got out the Blueprint but that was a gradual emergence, as I say, from this speech I gave in Chicago in 1946, and I had so many requests for it that I printed it.

Senator MURRAY. In this speech you were attacking the sponsors of the legislation?

Dr. SHEARON. Primarily not; no.

Senator MURRAY. Isn't that what this plat is intended to do, to question the integrity and honesty of the sponsors?

Dr. SHEARON. Where do I say that?

Senator SMITH. Senator Murray, I can see why you feel hurt by this, but as I understand it what Dr. Shearon was trying to show was the relationship and interest in this insurance with certain people in the Government.

Now certainly you wouldn't put on the chart the name of President Truman and imply he was a fellow-traveler, or anybody else. You wouldn't put the name of Dr. Parran, Dr. Dean Clark, whom I know intimately. I don't resent his name being here because he is in the Public Health Service. I would be the staunchest defender if anybody said anything to the effect that he was suspected of doing wrong. I think it has been a useful thing to have the issue brought up.

Dr. Falk has made a splendid statement of his position and the committee and the public will know what we have here, and I think Dr. Shearon coming before us today and explaining this thing has rendered a real service, and I hope we can get it straightened out and not have any more implications that something terribly wrong has been done.

Senator MURRAY. Well, Mr. Chairman, if this is a legal proceeding, I would say your point is somewhat leading. It is very helpful to the witness to have you make such an explanation because the way you stated it there you think it is entirely proper. I don't think it is proper.

I think she was acting on that conference committee at the time she was on this committee as a propagandist against the sponsors of the bill and she was seeking to circulate in the country propaganda designed to make the general public think that we were Communists or fellow-travelers and that we were under the total influence of an evil genius over here in the Social Security Administration who had developed this plan and put it ready made into our hands, and that we were mere tools.

Now I don't see how you can escape that conclusion from your plat, from this plat that you have sent out and through the various statements that you sent out while you were here in the committee.

Now I am very sorry to have to say that. I don't like to quarrel with you and I would very much like if you had just confined your activities to a study of the legislation, to an analysis of it, and then we could have gotten along very well.

I had no desire, no intention whatever to quarrel with you on the merits of the legislation, but when you try to make it appear that we are fellow-travelers and Communists and so forth——

Dr. SHEARON. Senator——

Senator SMITH. I can't see that that has been done at all.

Senator MURRAY. I don't see how anybody that can read the English language can get any other conclusion.

Senator SMITH. I suggest she continue with her testimony and see if her motives have been wrong. I want to be absolutely fair and have her present her case and just what motivated her, and then we can draw our conclusions as to just what the answer should be to this whole thing.

Certainly it is true we can't get away from this: Those in the Government here keenly interested in compulsory health insurance even though they knew it was a debatable matter, certainly were trying to sell that idea to the country, and if they were, why shouldn't Dr. Shearon be entitled to present the other side?

Senator MURRAY. I don't know of any proof before this committee that they were trying to sell anything to the country.

Senator SMITH. Now wait a minute. Let me just remind you that when Senator Pepper was chairman of the subcommittee a report was made coming from the subcommittee to which my name was added as a member. I had never been called to a meeting. The report was printed saying the committee decided compulsory insurance was the only answer and was circulated before I even saw a copy, and my name was on that.

Senator MURRAY. I was not on that committee.

Senator SMITH. That was done and it was for compulsory health insurance, and hundreds of thousands of copies were circulated and Senator Donnell protested on the floor about not having a member come in to read the report before it was approved. That was very wrong.

Senator MURRAY. That is a matter you can fight out with Senator Pepper. I don't know anything about that.

Senator SMITH. I am just trying to say that an assertion that there is no evidence of any attempt being made to try to sell Government compulsory health insurance to this country doesn't make sense to me. I'm sorry to say it but I have got to say that.

I suggest Dr. Shearon continue with her testimony so we can really get at what she did and see if she is open to criticism for what she has done. If she is, I will be the first to criticise. I want to see that this matter is handled in the absolutely fairest way possible.

Senator MURRAY. I reserve the right, of course, to further examine her on this subject.

Senator SMITH. Certainly, absolutely. You are entitled to the fullest cross-examination that you desire to make.

Dr. SHEARON. My experience in the field of health and medical legislation and programs covers a period of about 15 years. It includes work in a clinic for mental defectives, the development of an appraisal form for measuring community activities for mental defectives, and a year spent in New York State studying the history of public health organization in this country.

I have had experience with administration of medical care programs for the needy in New York City and in the Middle West. For the better part of 8 out of the past 10 years I have worked on health and medical legislation and on the development of plans for a national health program.

While at the Social Security Board from 1936 to 1941, my primary interest was in the field of old-age security. I prepared the economic brief entitled, "Economic Insecurity in Old Age" which the then Attorney General, Robert A. Jackson, used in defending titles II and

VIII of the Social Security Act before the Supreme Court, and I also furnished the major portion of the material which he used in defending titles III and IX.

I think that indicates I was regarded by the board as a competent professional worker to be given this very important assignment. I was assigned on loan to the general counsel of the Social Security Board for 5 months to do the job.

Senator DONNELL. Would that be entitled "Economic Insecurity In Old Age"?

Dr. SHEARON. It was printed and subsequently suppressed. Two hundred numbered copies were printed. I meant to bring a copy this morning and forgot to do it. They were given to the members of the United States Supreme Court, to the Department of Justice, which wrote the final brief from material that was given to them by the general counsel of the Social Security Board, and there were some copies available to the staff in the Social Security Board.

Not a single copy that I know of has ever gotten out. I think you will not find it in a library in the United States, not even in the Library of Congress. I had a copy bound which I intend to give the Library of Congress, but it is not to be found anywhere. It was used by members of the Social Security Board for their lecture work and so forth. It is perhaps the most fully documented single volume that we have, giving annotated bibliographical material and so forth, in the field of old-age insurance and social security.

Senator MURRAY. Mr. Chairman, I have not had an opportunity to go over her statement here this morning, and I would be glad to waive the right of cross-examining her now so we can expedite the hearings, with the understanding that at the close of her testimony I will be able to question her on any matter.

Senator SMITH. Oh certainly, Senator. Of course that is the way the committee ought to be conducted. We want to get the whole truth out. I think that might be wise, to let her make her complete statement. I appreciate it, Senator.

Dr. SHEARON. So do I, Senator.

On completing that task in 1937, I was assigned to the staff of Isidore Sydney Falk, then chief of health studies in the Bureau of Research and Statistics, of the Social Security Board, where I remained for 3½ years.

I say I was assigned. I was assigned by the Director of the Bureau, and did not seek the appointment.

I continued to work in the field of my primary interest, namely, the economic status of the aged, but devoted possibly 1½ years to medical and disability legislation and the study of compulsory sickness insurance administration. I worked on research documents for the National Health Conference called by President Roosevelt in 1938, and on the medical care provisions of the grants-in-aid title—that was title 13—of the 1939 Wagner health bill drafted by Mr. Falk and his staff.

I spent the entire year of 1940 on a report on the economic status of the aged, prepared at the request of the Social Security Board for the use of Congress and subsequently used by the Committee on Education and Labor in 1941.

That year I don't think I did anything in the health field at all. It was a major job that I did at the request of the Social Security Board in preparing this document for the use of Congress.

On completing that report early in 1941 I sought, and obtained, a transfer to the Public Health Service where I expected to continue my work on problems of the aged with Dr. Edward J. Stieglitz.

After I left the Social Security Board and Senator Downey asked me to serve as a consultant to the Labor Committee and I was permitted to do so by Mr. Paul V. McNutt and by Dr. Parran and I might say that I was at that time given entire freedom again to speak as a research person.

Dr. Stieglitz's resignation at the very moment of my transfer, resulted in my being assigned to the Division of Public Health Methods of which Mr. George St. John Perrott is chief.

And I might say that I had sought to leave the Bureau of Research and Statistics as early as 1939 or perhaps even a little earlier. I had quite a long interview with Dr. Parran in 1939. At that time Dr. Parran did not have the funds to take me on, but he expressed a wish to have me, so I went ahead and during my last year with the Bureau on Research and Statistics completed the report on old age, and then went over the Public Health Service.

I went there with the expectation of working with Doctor Stieglitz, M. D., on the problems of the aged. He was an expert in that field, and he was to handle the medical problems; I was to go into social and economic and other scientific problems, but at the very moment of my transfer he resigned for personal reasons, and as a result of that I was assigned to the Division of Public Health Methods of which Mr. George St. John Perrott is chief.

That division deals with statistics, health information, and health legislation. Thus I was again brought into the health field and had occasion to know a great deal about the drafting of the 1943 Wagner-Murray-Dingell bill and the preparations for the 1945 Wagner-Murray-Dingell bills.

During 1944 I was the only full-time employee in the Public Health Service working on postwar programs for national health, and at the request of Surg. Gen. Thomas Parran I prepared the "10-Year Postwar Program of the Public Health Service," which covers all phases of a National health program, including a description of each component program, the annual and 10-year costs, and the personnel required.

And I want to refer to that because I regard it as perhaps the best piece of work that I have done in this field. It was regarded as a monumental task by the Public Health Service. (Reference was made to "Proposed 10-Year Postwar Program of the Public Health Service.") It looks very heavy indeed, but it includes about 50 typewritten pages and the rest of it is supporting data, printed data, and charts and so forth, and I would like to ask this committee to consider the possibility of including as a part of my testimony the typewritten part of this program, and I will explain why.

In the beginning is an over-all statement by the Surgeon General. I prepared the entire thing myself. I did all of the writing and even the statement for Dr. Parran, and it was then cleared with all of the top people in the Public Health Service.

The preparatory work for this took me a solid year working with every division in the Public Health Service and with all the top leaders in the field. Most of them are scientific men. They are the kind of men that Dr. Friedman spoke of yesterday, men of integrity who are working very hard in the health field, who are devoted to their programs, men who are above reproach, shall we say. They are not particularly propagandists for anything, and I was very much sold on this program.

Well, now what I have here, then, is a brief over-all statement of 5 pages by the Surgeon General on the points in a 10-year program, and I might say that I did this for him at the request of the Bureau of the Budget. They wanted to know what a really fine health program would be for this country and what the 10-year costs would be, and what the personnel requirements would be also; and how the charges might be divided between the Federal Government and the State and local governments, and I prepared these charts on a 10-year basis with the over-all costs.

It is a very detailed thing. It is broken down by programs. I have the charts and then the supporting tables. You will see that it is really an elaborate piece of work. I then have it broken down by the four main bureaus in the Public Health Service, and under each bureau is a description of the programs that would be carried on by those bureaus and it covers every part of the field of health, including public health, nursing, sanitation, the infectious diseases, research and so on. There is a brief description of each one of the programs and the costs and the personnel required.

The volume met with the entire approval of, say, the top 25 people at the Public Health Service. There were the Surgeon General and the assistant surgeon general and the heads of the various bureaus, the men who were actively engaged in the health work of this country.

It was then submitted to Paul V. McNutt for approval and was approved by him late in 1944 and was then given to the Bureau of the Budget. They called up the Public Health Service and said it was a magnificent job and they wished every agency in the Government would submit to them something of this sort which would show what the activities of an agency would cost over a 10-year period so they could get a sensible budget. I think myself it was a very valuable piece of work. It was my last job for the Public Health Service.

Now what I am suggesting is this: In view of the fact that it does represent what this country might do in spending Federal funds, that just this typewritten part, without all of this other supporting material, this typewritten part which I think comes to about 50 pages, be incorporated here, as an expression, shall we say, of what I think would be a really fine health program for the country. If you want to spend any Federal money and don't want to spend an awful lot but spend what you do spend in a very good way, here is a suggestion and I will leave it to you for consideration. You might want to look it over before you pass on what you would like to do.

Senator SMITH. Would it be 50 printed pages?

Dr. SHEARON. No, 50 typewritten pages.

Senator SMITH. I would want to reserve judgment on it as to its relevancy with the pending legislation.

Dr. SHEARON. I will tell you exactly what the relevancy is, as a matter of fact. This, I might say, really expresses Dr. Parran's views when he speaks as a medical officer as the head of the Health Service of this country, without any other, shall we say, political consideration, and this includes my headings here, Post-War Goals for Health, The Physical Plant for Health, the Justification for Use of Public Funds, Hospital, and Health Centers, Expansion of Public Health Measures, the Public Support of Research, the Training of Health Personnel, the Implementation of a National Medical Care Program.

Now that is the part that would relate to your legislation under discussion, and at that time Dr. Parran felt that the Federal Government ought to do something for the low-income groups in the way of helping the States to provide medical care on a grant-in-aid basis, and he suggested then that we start out modestly with an appropriation of $100,000,000. That is a smaller appropriation than you have suggested in S. 545.

Senator MURRAY. Mr. Chairman, I might say that I have no objection to its being printed.

Senator SMITH. Will you express your thoughts, Senator Donnell?

Senator DONNELL. I think it should be printed.

Senator SMITH. I think it has a relevancy. It reflects on the over-all public health programs.

Dr. SHEARON. It represents the very best thought that I could get out of all the top health people of this country insofar as they are represented in the Public Health Service.

Senator SMITH. You edit the pages you want included for that and have a clean copy made for the record.

(The document referred to is as follows:)

PROPOSED 10-YEAR POSTWAR PROGRAM OF THE UNITED STATES PUBLIC HEALTH SERVICE

(Thomas Parran, M. D., Surgeon General, U. S. Public Health Service, November 1, 1944)

THE POSTWAR NATIONAL HEALTH PROGRAM OF THE UNITED STATES PUBLIC HEALTH SERVICE

Exhibit A. Total Federal expenditures for 10-year postwar program.
Exhibit A1. Expenditures for grants-in-aid, selected years.
Exhibit B. Per capita expenditures, percent of national income, and percent of all governmental expenditures required for proposed postwar health program.
Exhibit C. Cost, total and Federal, of 10-year health facilities construction program.
Exhibit D. Total annual Federal budget and personnel requirements for postwar health programs of the USPHS, selected years.
Exhibit E. Annual operating costs (administration, State services, and grants-in-aid), selected years.
Exhibit F. Annual expenditures, all sources and Federal, for facilities construction program, selected years.

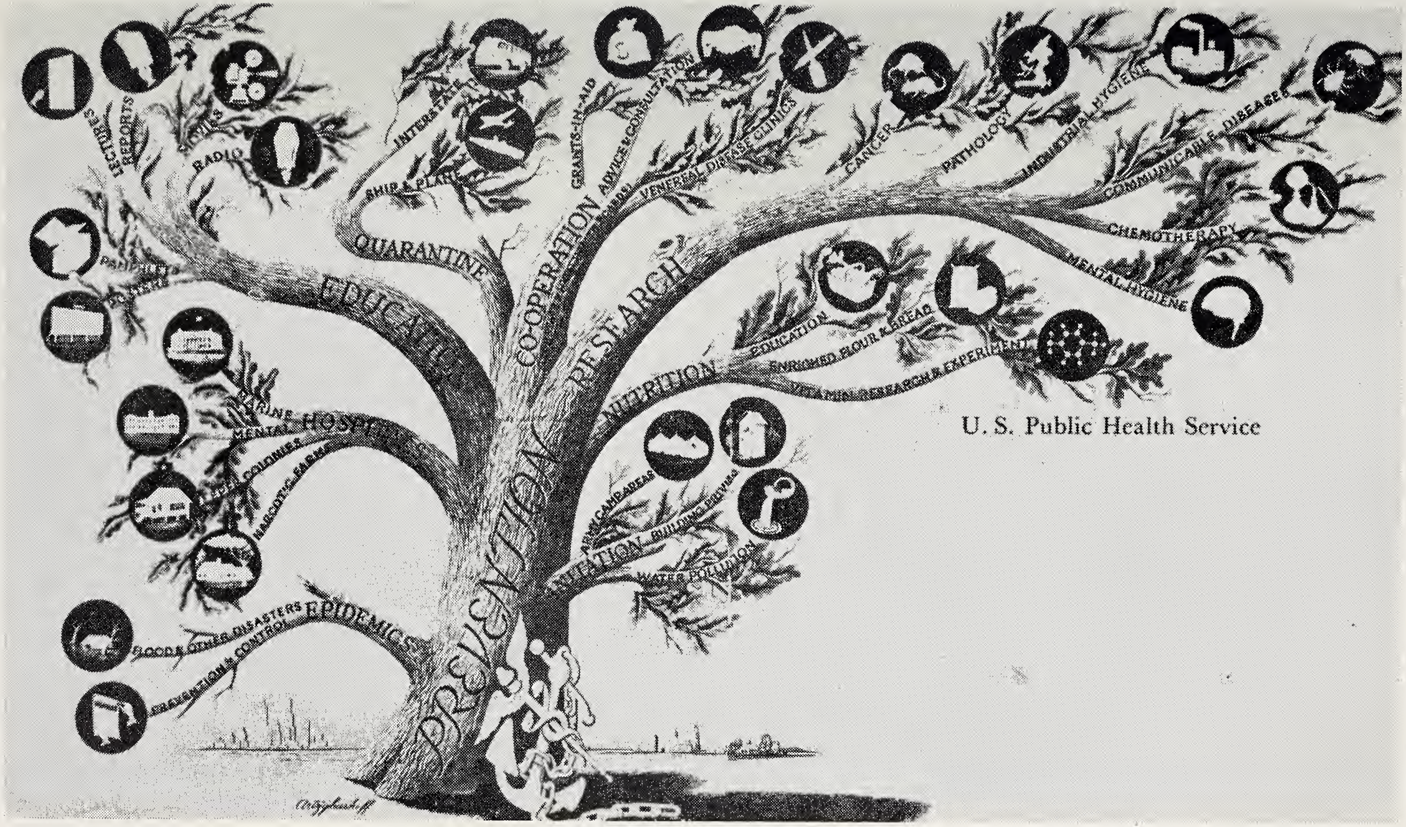
PROPOSED POSTWAR ACTIVITIES OF THE UNITED STATES PUBLIC HEALTH SERVICE

Office of the Surgeon General:
  Exhibit G. Postwar budget and personnel requirements
    Activities: A. Public health nursing
      B. Dental services
      C. Sanitary engineering
      D. Public Health Methods
National Institute of Health:
  Exhibit H. Postwar budget and personnel requirements
    Activities: E. Cancer control
      F. Infectious diseases research
      G. Physiology
      H. Research in oral diseases
      I. Zoology
      J. Industrial research
      K. Other scientific research

Bureau of Medical Services:
- Exhibit I. Postwar budget and personnel requirements
  - Activities: L. Marine hospitals
    - M. Foreign quarantine
    - N. Mental hygiene

Bureau of State Services:
- Exhibit J. Postwar budget and personnel requirements
  - Activities: O. General assistance to States for health services, including medical care
    - P. Control programs
    - Q. Hospital facilities
    - R. Venereal diseases
    - S. Industrial hygiene
    - T. Tuberculosis control

(Prepared by Marjorie Shearon, Ph. D., and Adela Stucke, A. B., from staff reports of the USPHS)


LECTURES
REPORTS
RADIO
PAMPHLETS
EDUCATION
QUARANTINE
SHIP & PLANE
INTERSTATE
GRANTS-IN-AID
ADVICE & CONSULTATION
CO-OPERATION
VENEREAL DISEASE CLINICS
RESEARCH
CANCER
PATHOLOGY
INDUSTRIAL HYGIENE
COMMUNICABLE DISEASES
CHEMOTHERAPY
MENTAL HYGIENE
NUTRITION
EDUCATION
ENRICHED FLOUR & BREAD
VITAMIN RESEARCH & EXPERIMENT
U. S. Public Health Service
MARINE
MENTAL
HOSPITALS
LEPER COLONIES
NARCOTIC FARMS
PREVENTION
SANITATION
ARMY CAMP AREAS
WATER POLLUTION
EPIDEMICS
FLOODS & OTHER DISASTERS
PREVENTION & CONTROL

STATUTORY MILESTONES

1798—The Marine Hospital Service created.
1901—Hygienic laboratory for investigation of infectious diseases built in Washington, D. C.
1912—Name changed to Public Health Service.
1918—Division of Venereal Diseases created.
1929—Division of Mental Hygiene established.
1935—Social Security Act passed—Title VI funds.
1937—National Cancer Act.
1938—Venereal Diseases Act; National Institute of Health moved to Bethesda, Md.
1939—Reorganization Act of 1939; Service transferred to Federal Security Agency.
1944—Public Health Act of 1944; Public Law 410.

(64431—48—pt. 5 (face p. 2236)

POSTWAR GOALS FOR HEALTH

When peace returns, this country should so reorganize and develop its health resources that there will be available to everyone in the population all health and medical services necessary for the prevention and promotion of health, the prevention of disease, and the treatment of illness. During the war we have learned to utilize to the fullest the health resources at our command. We have seen, too, more clearly than in peacetime, the deficiencies in those resources. We have come to realize that the administrative structure of both public and private health agencies will require modification to meet the heavier demands of the future. Gaps must be filled, overlaps eliminated.

Development of a comprehensive Nation-wide health program after the war calls for vigorous, integrated action on several fronts simultaneously. The job to be done cannot be accomplished by any one individual or group; it must be a cooperative enterprise. Those who have scientific knowledge in the fields of health and medicine will be expected to provide leadership, to establish standards, and to serve as technical consultants. The public at large, as well as industry, labor, and agriculture, must understand the objectives of the health program and must help in its development. Health is everybody's business.

PHYSICAL PLANT—TRAINED HEALTH PERSONNEL—ENLIGHTENED CITIZENRY

Three things are essential. First, we need the physical plant for health—community centers devoted to health activities; waterworks, sewers; small rural hospitals; urban polyclinics; and medical research centers; second, we need well-trained health personnel to man the physical plant and to render services in every community—scientists, doctors, dentists, nurses, sanitarians, technicians, and assistants; and third, we need an enlightened citizenry—men, women, and children who understand why we have the physical plant and the health personnel, who use both intelligently, and who, above all else, are aware of their personal, individual responsibility in achieving health.

USE OF PUBLIC FUNDS JUSTIFIED

These are goals. They will not be attained overnight. But within a decade notable progress might be made if money were spent where there is reason to believe it would do the most good and if efforts were made in the directions most likely to yield results. Briefly, it is proposed to raise the health level of the entire country by completing the sanitary foundations of our cities, towns, and farms, and by making easily accessible to everyone the health and medical services necessary to keep the individual physically and mentally fit and to care for him when he is disabled by accident or illness. It is believed that the use of public funds is fully justified in developing the physical plant for health, in training professional personnel, in supporting both public and private medical and scientific research of broad public interest, and in reducing the individual financial burden resulting from catastrophic illness or chronic disability.

The principle is accepted that no one in the United States should be denied access to health and medical services because of economic status, race, geographical location, or any other nonhealth factor or condition. It is a duty of governments—local, State, and Federal—to guarantee healthful living conditions and to enable every person to secure freedom from preventable diseases.

In the 10-year postwar health program of the United States Public Health Service it is proposed that efforts and funds be concentrated in the six fields of activity believed to be most fruitful and most in need of governmental stimulation and aid.

I. Assurance of a sanitary environment

Our first duty is to assure a sanitary environment to every person in the population. Present deficiencies in sanitation facilities should be met by (*a*) extension and improvement of public water supplies, construction of sewerage systems in cities now inadequately served, and construction of municipal or other treatment plants to take care of domestic sewage and industrial wastes that now threaten pollution of water supplies; (*b*) development of community sanitation programs in rural areas to provide safe water supplies and sanitary methods for disposal of excreta; (*c*) construction of milk pasteurization plants in the relatively few communities where the milk supply is not yet protected; and (*d*) completion of other local sanitation facilities required to make our cities, towns, and farming communities healthful places in which to live.

II. Provision of hospitals and health centers

Where need is demonstrated, hospitals and health centers should be provided. Surveys of need for general and special hospitals should be made by competent experts in each State. These surveys should precede the drafting of master plans. New hospitals should be located and built in conformity with the master plan in each State and should be architecturally sound and functionally adequate. General hospitals, constituting service foci for the more equitable distribution of medical services, should be related administratively both to the large medical centers and to the nearby smaller hospitals and health centers. Additional hospitals should be built for persons suffering from tuberculosis and mental disease. Far better provision should be made for the care of chronic, convalescent, and cancer patients. Finally, obsolete hospital structures should be replaced by modern, functional buildings. As soon as manpower and materials are available, construction of some 2,400 well-equipped health centers should be undertaken. Such centers would serve the health needs of local communities in much the same way that grade schools meet local educational needs.

III. Expansion of public-health measures

Probably nothing would yield greater results in raising the general level of the health of the people than an expansion of current public-health measures. To facilitate the more equitable distribution of personal health services after the war, the entire field of public-health nursing should be expanded. Beside nursing should be accepted as a public-health function and should be included as a regular activity in every local health department. A dental service program for children should be inaugurated as soon as personnel and equipment become available and at the same time an adequate program should be developed for extension of the dental services to the rest of the population as soon as this is feasible. New or expanded services should be developed for the early diagnosis and treatment of cancer and of other diseases of middle and later life. Measures likewise should be taken for the detection of diseases and conditions due to malnutrition and for the development of an industrial nutrition service. Tuberculosis control measures should be stepped up sharply with the aid of mass case-finding techniques already known and tested. Prompt action should be taken to strengthen and extend control measures as a protection against the spread of malaria, plague, typhus, and other tropical diseases which heretofore have not been a threat to us in the United States.

IV. Public support of research

In many conditions good medical care cannot be made available to the patient simply because science has not yet found effective methods of treatment or prevention. Under the stimulus of wartime necessity, tremendous progress has been made in developing effective control and treatment for diseases and conditions of military importance through coordinated research in many centers. An extensive system of grants-in-aid to research institutions has been developed, and there has been intimate collaboration similarly with our major allies. The need for a continuation and expansion of this type of governmental support of research will be of equal importance in the postwar period. The expenditure of modest sums from public funds to support the best research minds of the country, working in properly staffed and equipped institutions, would speed up the expansion of our knowledge of health and disease and thereby be of incalculable public benefit.

Such increased support of research should be carried out both through additional federally operated institutions, based upon the National Institute of Health, through grants-in-aid to State and private institutions, and through a system of research fellowships designed to locate and train promising research ability.

The shrinkage of private funds to support scientific research and the increasing cost of comprehensive studies, entailing as it does the construction and equipment of expensive laboratories, poses a serious stituation for research institutions. Governmental support toward the solution of basic scientific problems in the health field should assure continuous effort over the long period of years often necessary to solve a scientific problem. Priority would be given to research efforts designed to solve those great causes of disease, disability, and death which loom large in the national health picture and which require for their solution coordinated group action utilizing many and varied scientific disciplines. Some of these problems such as mental and nervous illness, nutrition, industrial hygiene, and dental defects require nationl research institutes like the National

Cancer Institute, to furnish a center where both laboratory and clinical studies are carried out and through which functional relations are maintained with all other institutions in the country working on the same problem.

Additional field research laboratories supported by Federal funds are required for basic studies of sanitation and for investigation of measures to suppress plague, typhus fever, malaria, and other tropical diseases, and for training of health personnel in the techniques required to deal with these problems.

State and other governmental agencies now spend each year more than $200,000,000 on care of the mentally ill but less than $1,000,000 on research into the causes and possible methods of preventing mental illness. Over half the hospital beds of the country are occupied by patients suffering from mental illness and still more beds are required to keep up with the demands of lengthening waiting lists. Similarly, though the national expenditure for dental care amounts to $500,000,000 a year, funds have not been available to pursue the research and field demonstrations on methods for the prevention of dental caries.

Other fields of research scarcely touched but in need of intensive cultivation are those dealing with the degenerative diseases, cancer, diseases of the heart and kidney, and other diseases which may be expected to take an increasing toll through premature death and disability as our population ages.

Unless, as a nation, we wish to spend even larger sums for institutions to house patients suffering from chronic conditions which might, in many instances, have been prevented and unless we wish to force increasing numbers of workers into the ranks of unemployables because of accidents, occupational diseases, and other physical and mental conditions that should have been prevented or for which science may be expected to yield a cure—unless, then, we wish to continue to waste our human and financial resources as we have in the past, I am convinced there must be public recognition of the need for adequate sums for scientific research.

V. Training of health personnel

To carry out an effective national health program that will move forward on all fronts under competent leadership, carefully selected, well-trained health personnel are required. Nurses, laboratory technicians, and sanitarians are needed in addition to doctors, dentists, and other practitioners. Training facilities and funds to aid in meeting the costs of tuition and maintenance should be made available. Through joint action by public and private agencies, administrative machinery should be set up to facilitate the distribution of health personnel, already trained or to be trained, to places where the need is great.

VI. Implementation of national medical-care program

To round out the personal health services which should be available under a public-health program it will be necessary to add to the nursing and dental services already proposed a medical-care service for those communities or groups in the population which are unable to obtain satisfactory medical services as measured by current standards. It is proposed that a national medical care program be implemented through Federal grants-in-aid to States wishing to expand their medical-care services. Such funds might be used locally to pay for (*a*) the services of physicians working in remote or economically depressed areas, (*b*) part of the cost of various clinics, (*c*) all or part of the cost of certain expensive diagnostic services which now bear heavily on workers and their families, or (*d*) part of the cost of care in general hospitals.

COST OF 10-YEAR PROGRAM

The national health program here envisaged would call for an outlay of roughly $14,000,000,000 of public funds—Federal, State, and local—during the first decade after the war. One half the total might appropriately be furnished by the Federal Government, the other half by State and local governments. Or the proportions might be modified in conformity with over-all fiscal policy. Roughly, this would mean that an annual per capita expenditure of $10 from public funds would (1) set up the physical plant for health in this country and would provide the more essential sanitation facilities presently needed; (2) man the health plant with qualified personnel and, when necessary, aid in training additional personnel to serve as private practitioners and technical aids; and (3) provide for the maintenance and operation of the physical plant for a decade, at the same time maintaining the services believed to be essential for national health.

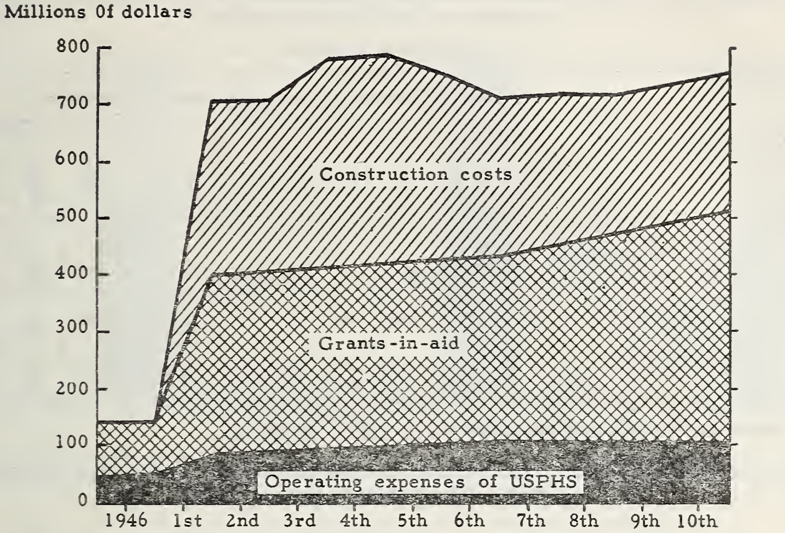
COSTS TO BE MET FROM GENERAL REVENUES

It is proposed that these basic health services be made available at public expense and that for the most part they be financed through general taxation. In this way the cost would not bear heavily on any single group. A national problem should be met by the Nation as a whole, each person contributing according to ability to the general revenues—local, State, and Federal—from which adequate appropriations should be made. If it be assumed that a method will be devised to stabilize national income at $160,000,000,000 a year after the war and if reasonably full employment be achieved, the proposed expenditures would amount to less than 1 percent of national income and only 3.5 percent of all governmental expenditures—Federal, State, and local. (See exhibit B.)

Fiscal and administrative implications of the 10-year postwar national health program of the U. S. Public Health Service

	Exhibit
1. Total expenditures, from all sources, for 10-year postwar national health program estimated at about $14,000,000,000, or $10 per capita per year	A and C.
2. Total Federal expenditures, all programs, for 10-year period estimated at $7,400,000,000	A.
3. 40 percent of Federal expenditures would be for construction of health facilities, 46 percent for grants-in-aid, and 14 percent for operating expenses, including demonstrations	A.
4. Grants-in-aid for all programs, except facilities construction, would rise from $93,000,000 in 1946 to $307,000,000 in first postwar year to $403,000,000 in tenth postwar year	A–1.
5. Grants-in-aid for research and training would rise from $64,000,000 in 1946 to $97,000,000 in first postwar year and would level off at $33,000,000 annualy from sixth to tenth postwar years	A–1.
6. Total cost for 10-year facilities construction program would amount to $6,300,000,000 from all sources, at least $3,000,000,000, or 47 percent, coming from Federal funds	C.
7. Public Health Service budget would rise from $145,000,000 in 1946 to $396,000,000 in first postwar year to $507,000,000 in tenth postwar year	E.
8. Public Health Service personnel at end of 10 years would be nearly double present personnel, rising from 17,403 persons in 1946 to 24,444 during first postwar year, and to 29,209 in sixth and 33,185 in tenth postwar years, respectively	E.

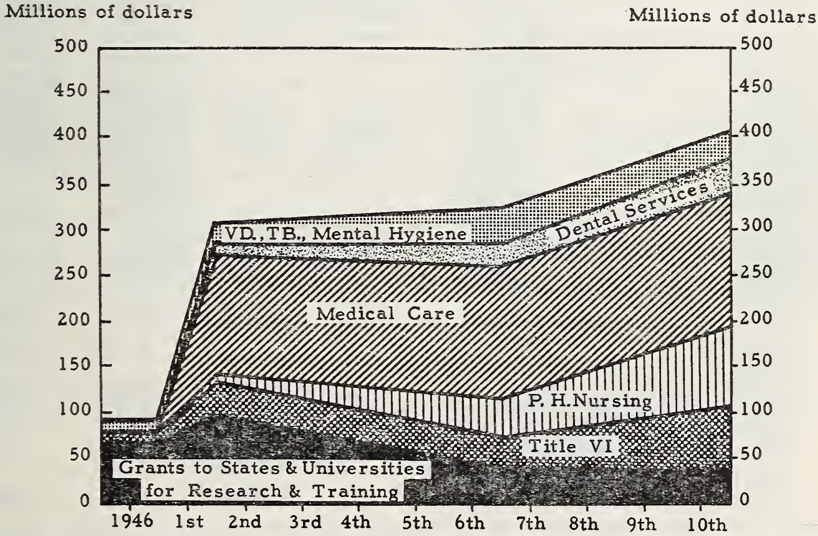
CHART 1



AS - 10/21/44

Total estimated Federal expenditures for the proposed postwar national health program, by postwar fiscal years.

CHART 2



Adela Stuke
10/24/44

Total estimated Federal expenditures for grants-in-aid, exclusive of construction grants, to implement proposed national health program, by programs and postwar fiscal years.

Exhibit A.—*Total estimated Federal expenditures for the proposed 10-year postwar national health program*

[In millions of 1943 dollars]

Type of expenditure	Federal expenditures, all programs, by postwar fiscal years											
	Total		First	Second	Third	Fourth	Fifth	Sixth	Seventh	Eighth	Ninth	Tenth
Total for the United States	*Percent* 100	$7,357	$707	$709	$775	$782	$752	$711	$719	$715	$734	$753
Health facilities construction program	40	[1] 2,965	311	306	365	365	329	281	269	246	246	246
Operating expenses, exclusive of grants-in-aid, all programs	14	1,005	89	92	96	99	103	106	106	105	105	104
Grants-in-aid	46	3,388	307	311	314	318	320	324	344	364	383	403

[1] Due to rounding, this total is $1,000,000 in excess of actual summation.

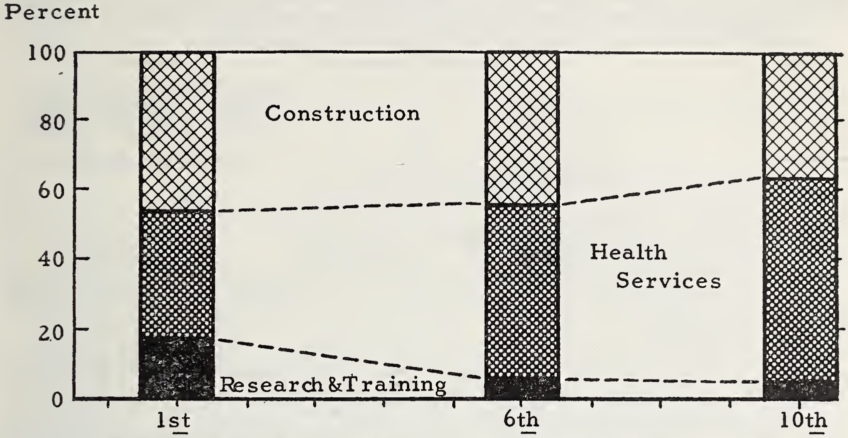
Exhibit A–1.—*Proposed expenditures for grants-in-aid, by programs, fiscal year 1946 and first, sixth, and tenth postwar fiscal years*

Grant-in-aid program	Fiscal year ending June 30, 1946	First postwar fiscal year	Sixth postwar fiscal year	Tenth postwar fiscal year
Total, all programs	$93,270,319	$307,341,974	$323,706,875	$402,746,875
Grants to States for health services	29,308,345	210,000,000	290,250,875	370,050,875
General health program (title VI)	11,000,000	33,219,955	33,920,663	70,625,430
Public health nursing [1]	----------	4,021,700	44,000,000	88,000,000
To implement a national medical-care program	----------	140,000,000	143,800,000	147,000,000
Dental services	----------	7,000,000	25,000,000	37,000,000
Venereal diseases	9,827,800	16,427,800	19,862,337	8,057,570
Tuberculosis control	8,480,545	8,480,545	12,500,000	8,200,000
Mental hygiene	----------	850,000	8,717,000	8,717,000
Industrial hygiene	(2)	(2)	2,450,875	2,450,875
Grants to States, universities, and schools for research, training, and surveys	63,961,974	97,341,974	33,456,000	32,696,000
Nurse education (to institutions and schools for training)	63,770,974	77,020,974	13,250,000	13,250,000
For special training in public health nursing	----------	1,000,000	2,500,000	3,500,000
National Institute of Health (to universities for research)	100,000	7,000,000	7,000,000	7,000,000
Cancer Institute (to hospitals for research)	91,000	146,000	146,000	146,000
Industrial hygiene (to universities for training)	----------	----------	500,000	500,000
Mental hygiene (to States for demonstration and training)	----------	150,000	1,500,000	1,500,000
Stream pollution abatement (to States)	----------	1,500,000	1,500,000	1,500,000
Sanitation research (to States)	----------	750,000	750,000	750,000
Dental research (to States)	----------	75,000	450,000	450,000
Surveys for hospital construction program (to States)	----------	5,000,000	----------	----------
Administration of hospital construction program (to States)	----------	4,700,000	5,860,000	4,100,000

[1] Over and above any amount included for public health nursing in venereal-disease grants. These sums now amount to about 15 percent of venereal-disease grants and will drop to 10 percent and 5 percent in the sixth and tenth postwar years, respectively.

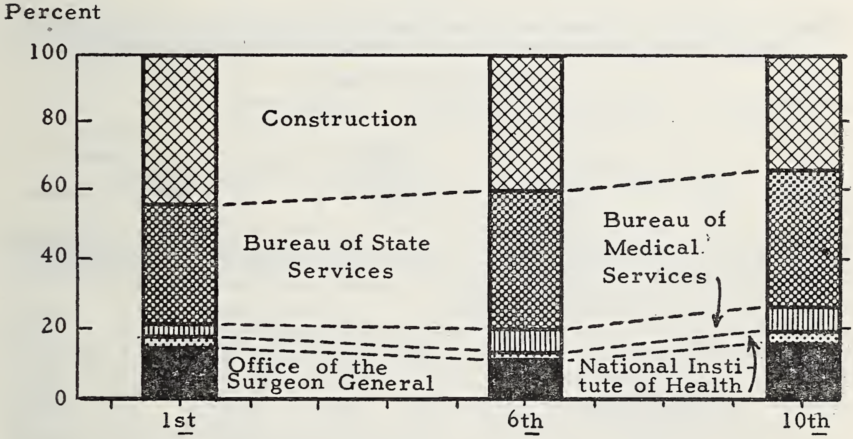
[2] Derived from title VI funds.

CHART 3



Percent of Federal grants-in-aid to be spent for construction, services, and research and training by the U. S. Public Health Service—first, sixth, and tenth postwar fiscal years.

CHART 4



10-31-44

Percent of total U. S. Public Health Service budget required for construction grants and for all other expenditures—first, sixth, and tenth postwar fiscal years.

EXHIBIT B.—*Per capita expenditures, percent of national income, and percent of all governmental expenditures required to implement the proposed postwar national health program during the first postwar fiscal year* [1]

Expenditures by source of funds	Total cost	Percent of national income [2]	Percent of all governmental costs [3]	Per capita costs [4]
Over-all expenditures for health, first postwar year	$1, 408, 000, 000	0. 88	3. 5	$10
Federal expenditures: Administration, demonstrations, grants-in-aid, including construction grants	707, 000, 000	. 44	1. 8	5
State and local expenditures [5]	701, 000, 000	. 44	1. 7	5

[1] Per capita expenditures would be roughly the same in the tenth postwar year, but the percent of national income and of the total governmental expenditures for goods and services might conceivably decline, although this is conjectural.

[2] National income assumed to be stabilized at $160,000,000,000 in early postwar years.

[3] Total expenditures for all governmental goods and services, Federal, State, and local, estimated at $40,600,000,000 if national income of $160,000,000,000 is maintained. (Unpublished estimate of Bureau of Labor Statistics, Division of Postwar Labor Problems.) While it is here assumed that State and local governments will provide roughly one-half the cost of the total program, this assumption will probably have to be changed in the light of present estimates of postwar State and local fiscal ability to match Federal grants. Before the war State and local governments spent $9,000,000,000 to $10,000,000,000 a year for goods and services; after the war they may be able to pay $12,000,000,000. This latter amount is only 30 percent of the total estimated postwar budget for all governmental goods and services, Federal, State, and local.

[4] Population estimated at 140,000,000 persons in 1946, 143,800,000 in 1951, and 147,000,000 in 1955. (Unofficial estimates, Bureau of the Census.)

[5] Those amounts include some private funds, of unknown amount, notably those contributed toward the cost of hospital projects.

EXHIBIT C.—*Estimated total cost of the proposed 10-year postwar health facilities construction program and proposed extent of Federal participation*

[In thousands of 1943 dollars]

Type of facility	Assumed number of construction years [1]	Estimated cost [2]	Federal funds	
			As percent of total cost	Amount
Total for the United States	10	$6, 300, 043	47	$2, 965, 057
A. State and local construction programs	10	6, 209, 492	46	2, 874, 506
1. Hospitals (general, tuberculosis, mental, and chronic diseases)	10	[3] 2, 421, 000	[3] 45	1, 089, 500
2. Health centers	10	[3] 133, 333	60	80, 000
3. Sanitation facilities	10	3, 511, 574	46	1, 627, 214
(*a*) Public water supply	10	[4] 803, 300	35	277, 139
(*b*) Sewerage	10	[4] 2, 255, 150	50	1, 127, 575
(*c*) Rural sanitation	10	445, 000	50	222, 500
(*d*) Food sanitation	5	8, 124	0	
4. Control programs	5	143, 585	54	77, 7920
(*a*) Typhus control	5	65, 585	50	32, 792
(*b*) Plague control	10	18, 000	50	9, 000
(*c*) Malaria eradication	5	60, 000	60	36, 000
B. New construction, extension of existing facilities, replacements, repairs, etc., for the Public Health Service	5	90, 551	100	90, 551
1. New postwar construction, alterations, etc., for the National Institute of Health [5]	1	23, 364	100	23, 364
2. New marine hospitals and replacements; replacement of 2 quarantine stations; and extension of 2 existing PHS hospitals [5]	5	60, 985	100	60, 985
3. Regional laboratory building projects needed by the Bureau of State Services	1	2, 002	100	2, 002
4. Expansion of present departmental headquarters building and construction of new building on Virginia Ave., Washington, D. C	1	4, 200	100	4, 200

[1] Arbitrary assumption; some of the 10-year programs could be spread over 20 years or compressed into fewer than 10 years.

[2] Includes an unknown amount to be derived from private sources especially in the case of hospital projects.

[3] Cost of site acquisition assumed to be 10 percent of over-all cost; great variation from project to project.

[4] Cost of site acquisition, estimated at 1 percent of over-all cost, not included.

[5] Cost of site acquisition included.

Exhibit D.—*Total annual Federal budget and personnel requirements for all postwar health programs of the U. S. Public Health Service, first, sixth, and tenth postwar fiscal years*

[In millions of 1943 dollars]

Type of expenditure	First postwar fiscal year		Sixth postwar fiscal year		Tenth postwar fiscal year	
	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget
Grand total	24, 444	$707	29, 209	$711	33, 185	$753
Health facilities construction program	----------	311	----------	281	----------	246
Hospitals and health centers	----------	93	----------	117	----------	82
Sanitation facilities	----------	163	----------	163	----------	163
Control programs	----------	14	----------	1	----------	1
New construction, replacement, repairs, etc., for the Public Health Service	----------	41	----------	0	----------	1
Operating expenses, exclusive of grants-in-aid, all programs	24, 444	89	29, 209	106	33, 185	104
Grants-in-aid	----------	307	----------	324	----------	403
For State health services	----------	210	----------	290	----------	370
For research, training, and surveys	----------	97	----------	34	----------	33

Exhibit E.—*Postwar budget and personnel requirements of the U. S. Public Health Service, fiscal year 1946 and first, sixth, and tenth postwar fiscal years*

Bureau	Fiscal year ending June 30, 1946		First postwar fiscal year		Sixth postwar fiscal year		Tenth postwar fiscal year	
	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget
Grand total	17, 403	$144, 460, 283	24, 444	$396, 343, 271	29, 209	$429, 788, 809	33, 185	$507, 292, 672
	Operating expenses							
Total	17, 403	$51, 189, 964	24, 444	$89, 001, 297	29, 209	$106, 081, 934	33, 185	$104, 545, 797
Office of the Surgeon General	1, 330	6, 333, 169	5, 349	21, 349, 824	4, 391	18, 497, 977	4, 487	18, 942, 304
National Institute of Health	803	2, 607, 751	2, 916	8, 902, 931	3, 404	10, 358, 163	3, 444	10, 550, 183
Bureau of Medical Services	7, 071	20, 778, 896	7, 105	21, 115, 130	9, 901	30, 466, 150	12, 159	36, 180, 150
Bureau of State Services	8, 199	21, 470, 148	9, 074	37, 633, 412	11, 513	46, 759, 644	13, 095	38, 873, 160
	Grants-in-aid							
Total	-------	$93, 270, 319	-------	$307, 341, 974	-------	$323, 706, 875	-------	$402, 746, 875
Office of the Surgeon General	-------	63, 770, 974	-------	79, 270, 974	-------	62, 000, 000	-------	107, 000, 000
National Institute of Health	-------	191, 000	-------	7, 146, 000	-------	7, 146, 000	-------	7, 146, 000
Bureau of Medical Services	-------	------------	-------	1, 000, 000	-------	10, 217, 000	-------	10, 217, 000
Bureau of State Services	-------	29, 308, 345	-------	219, 925, 000	-------	244, 343, 875	-------	278, 383, 875

Exhibit F.—*Estimated annual expenditures from all sources for the proposed postwar health facilities construction program, first, sixth, and tenth postwar fiscal years*

[In millions of 1943 dollars]

Type of facility	Total expenditures in specified postwar years					
	All sources			Federal		
	First	Sixth	Tenth	First	Sixth	Tenth
Total for the United States	$630	$607	$531	$311	$281	$246
A. State and local construction programs	589	607	531	270	281	246
1. Hospitals (general tuberculosis, mental, and chronic diseases) [1]	204	255	179	93	117	82
2. Health centers [1]						
3. Sanitation facilities	358	350	350	163	163	163
(*a*) Public water supply [2]	80	80	80	28	28	28
(*b*) Sewerage [2]	226	226	226	113	113	113
(*c*) Rural sanitation	44	44	44	22	22	22
(*d*) Food sanitation	8	0	0	0	0	0
4. Control programs	27	2	2	14	1	1
(*a*) Typhus control	13	0	0	6	0	0
(*b*) Plague control	2	2	2	1	1	1
(*c*) Malaria eradication	12	0	0	7	0	0
B. New construction, extension of existing facilities, replacements, repairs, etc., for the Public Health Service	41	0	0	41	0	0
1. New postwar construction, alterations, etc., for the National Institute of Health	23	0	0	23	0	0
2. New marine hospitals and replacements: replacement of 2 quarantine stations; and extension of 2 existing PHS hospitals	12	0	0	12	0	0
3. Regional laboratory building projects needed by the Bureau of State Services	2	0	0	2	0	0
4. Expansion of present departmental headquarters building and construction of new building on Virginia Ave., Washington, D. C.	4	0	0	4	0	0

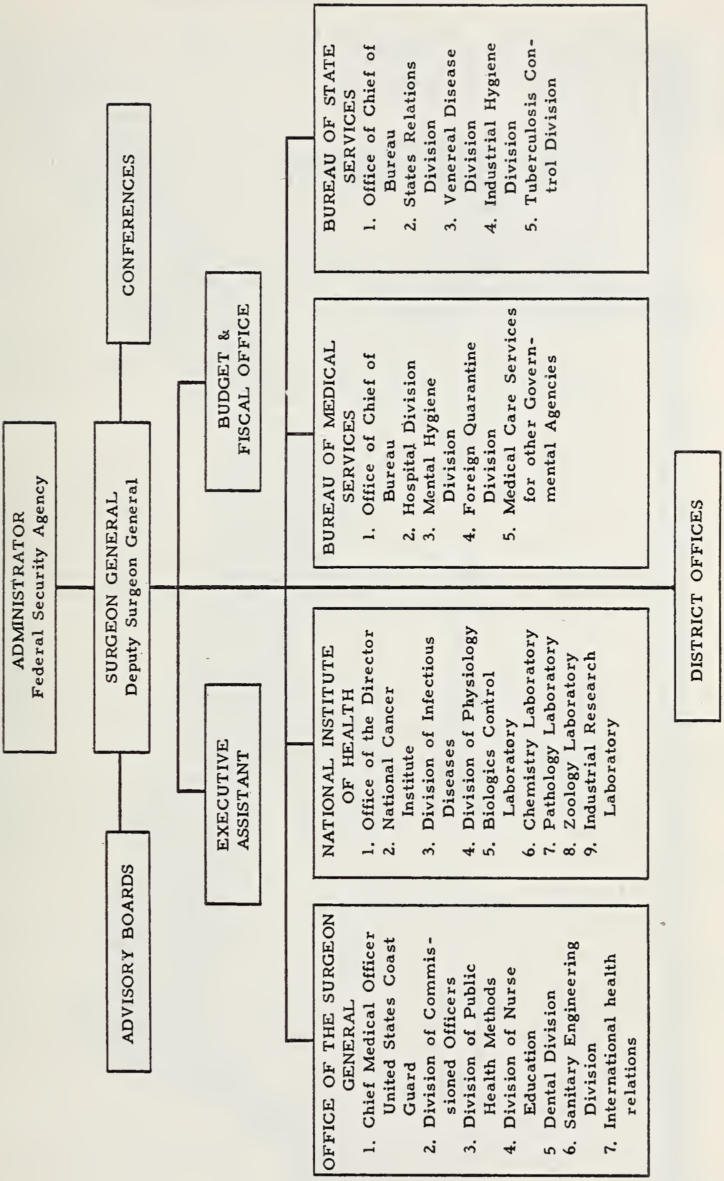
---

[1] It is assumed there will be some delay in getting the hospital and health centers construction program in operation because of the time required to make State and local surveys and to develop master plans. Annual expenditures here given are based on the assumption that 60 percent of this program will be completed in the first 5 postwar years, the percentage for successive years being 8, 10, 15, 15, 12. Percentages for the successive 5 years are asumed to be 10, 9, 7, 7, 7.

[2] Because of the lack of information on the rate at which construction might get under way in the case of the public water supplies and sewerage projects, a uniform annual rate has been assumed for the 10-year period.

FUNCTIONAL CHART

U. S. Public Health Service


ADMINISTRATOR
Federal Security Agency
SURGEON GENERAL
Deputy Surgeon General
ADVISORY BOARDS
CONFERENCES
EXECUTIVE ASSISTANT
BUDGET & FISCAL OFFICE
OFFICE OF THE SURGEON GENERAL
1. Chief Medical Officer United States Coast Guard
2. Division of Commissioned Officers
3. Division of Public Health Methods
4. Division of Nurse Education
5 Dental Division
6. Sanitary Engineering Division
7. International health relations
NATIONAL INSTITUTE OF HEALTH
1. Office of the Director
2. National Cancer Institute
3. Division of Infectious Diseases
4. Division of Physiology
5. Biologics Control Laboratory
6. Chemistry Laboratory
7. Pathology Laboratory
8. Zoology Laboratory
9. Industrial Research Laboratory
BUREAU OF MEDICAL SERVICES
1. Office of Chief of Bureau
2. Hospital Division
3. Mental Hygiene Division
4. Foreign Quarantine Division
5. Medical Care Services for other Governmental Agencies
BUREAU OF STATE SERVICES
1. Office of Chief of Bureau
2. States Relations Division
3. Venereal Disease Division
4. Industrial Hygiene Division
5. Tuberculosis Control Division
DISTRICT OFFICES

Office of the Surgeon General

1. Chief Medical Officer, United States Coast Guard.
2. Division of Commissioned Officers.
3. Division of Public Health Methods.
4. Division of Nurse Education.
5. Dental Division.
6. Sanitary Engineering Division:
    - (*a*) Stream pollution investigations.
    - (*b*) Facility security.
    - (*c*) Milk and food.
    - (*d*) General sanitation.
    - (*e*) Vessel sanitation.
    - (*f*) Stream sanitation.
    - (*g*) Water and sewage.
7. International health relations.

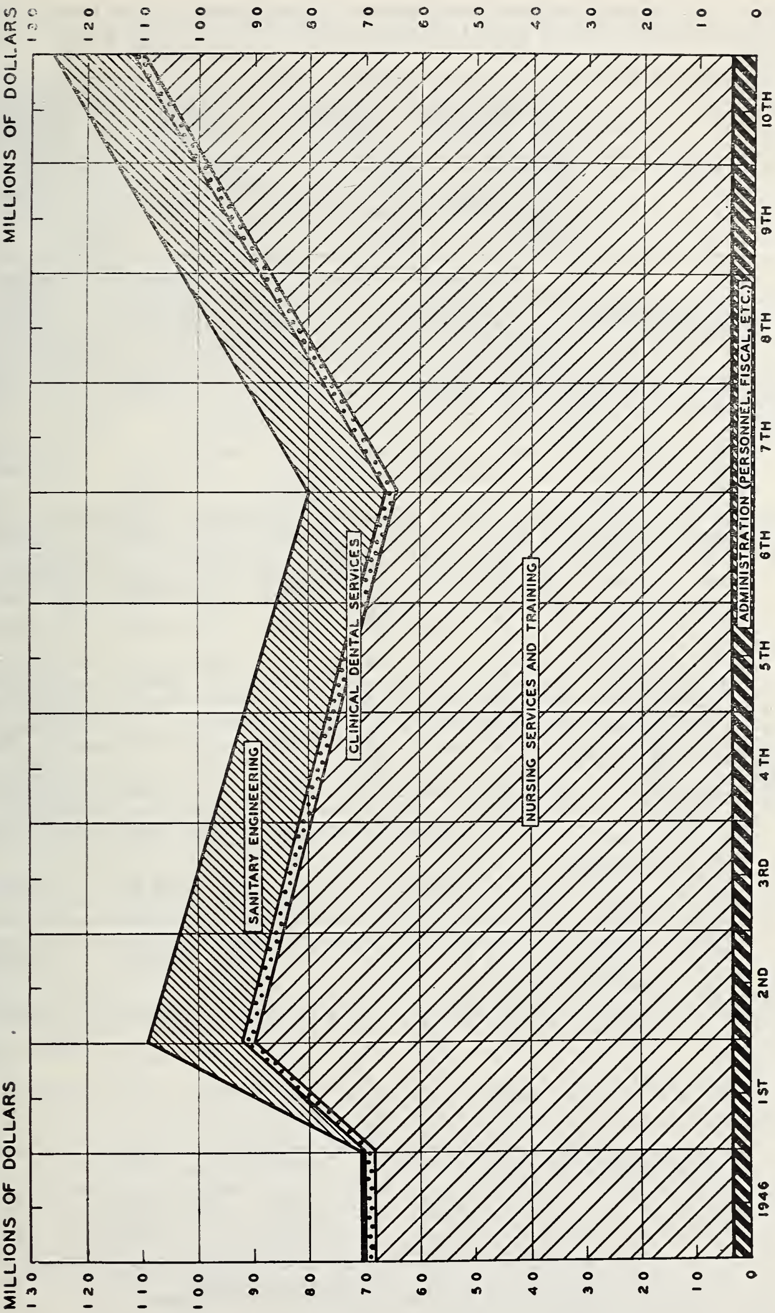

MILLIONS OF DOLLARS
MILLIONS OF DOLLARS
0
10
20
30
40
50
60
70
80
90
100
110
120
130
1946
1ST
2ND
3RD
4TH
5TH
6TH
7TH
8TH
9TH
10TH
SANITARY ENGINEERING
CLINICAL DENTAL SERVICES
NURSING SERVICES AND TRAINING
ADMINISTRATION (PERSONNEL, FISCAL, ETC.)

Exhibit G.—*Postwar budget and personnel requirements of the Office of the Surgeon General, fiscal year 1946, and first, sixth, and tenth postwar fiscal years*

Division	Fiscal year ending June 30, 1946		First postwar fiscal year		Sixth postwar fiscal year		Tenth postwar fiscal year	
	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget
Total budget		$70,104,143		$100,668,769		$80,436,923		$125,794,030
Total operating expenses		6,333,169		21,397,795		18,436,923		18,794,030
Total grants-in-aid		63,770,974		79,270,974		62,000,000		107,000,000
Total personnel	1,330		5,360		4,377		4,453	
Surgeon General's Office	7		7		7		7	
Salaries		19,380		19,380		19,380		19,380
Sanitary Engineering Division:								
Headquarters and Cincinnati field office	130		283		465		502	
Operating expenses		525,641		[1] 1,118,168		[1] 1,772,055		[1] 1,909,282
Grants to States for sanitation research				750,000		750,000		750,000
Rural sanitation			3,040		2,015		2,015	
Operating expenses				9,500,000		6,500,000		6,500,000
Stream-pollution abatement			213		213		213	
Operating expenses				1,300,000		1,300,000		1,300,000
Grants to States				1,500,000		1,500,000		1,500,000
Public water supply			206		206		206	
Operating expenses				1,250,000		1,250,000		1,250,000
Sewer systems and extensions			206		206		206	
Operating expenses				1,250,000		1,250,000		1,250,000
Milk pasteurization			2					
Operating expenses				52,000				
Budget and Fiscal Office	140		140		145		145	
Operating expenses		238,000		238,000		375,000		375,000
Public Health Methods Division	117		117		117		117	
Operating expenses		358,285		362,285		362,285		362,285
Division of Nursing:[2]								
Nurse education	171		226		45		45	
Operating expenses		1,012,784		1,277,784		265,000		265,000
Grants to schools and institutions for training		63,770,074		77,020,974		13,250,000		13,250,000
Public health nursing	(3)	(3)	(3)	(3)	177		216	
Operating expenses	(3)	(3)	(3)	(3)		490,685		591,605
Grants to States for services	(3)	(3)	(3)	(3)		44,000,000		88,000,000
Grants for training	(3)	(3)	(3)	(3)		2,500,000		3,500,000
Dental Division (clinical dental services)	329		339		287		287	
Operating expenses		1,836,860		2,111,860		1,908,040		2,027,000
Division of Commissioned Officers	25		25		25		25	
Operating expenses		58,809		58,809		58,809		58,809
Commissioned officers not allocated to divisions[4]	220		220		220		220	
Salaries, etc		1,624,795		1,624,795		1,624,795		1,624,795
In-service training program			144		144		144	
Operating expenses				572,899		572,899		572,899
Civil Service Personnel Section	99		100		105		105	
Operating expenses		180,640		183,840		210,000		210,000
Chief Clerk's office	92		92		(5)		(5)	
Operating expenses		477,975		477,975		477,975		477,975

---

[1] Includes laboratory facilities provided for States Relations Division project.

[2] Assume that by the sixth postwar year all nursing functions will be in 1 division.

[3] Transferred from States Relations.

[4] Includes commissioned officers assigned to Coast Guard, Prison Service, Army, Foreign Economic Administration, etc.; also death gratuity and burial benefits, additional pay for foreign service, etc., not allocated to the several bureaus.

[5] To be computed when all other figures have been compiled.

Public Health Nursing and Nurse Education

POSTWAR NEEDS FOR MORE PUBLIC HEALTH NURSES

More than 20,000 public health nurses are employed in the United States and Territories by Federal, State, and local governmental agencies, by insurance companies and industrial plants, and by voluntary organizations such as the visiting nurse associations. This number should be increased nearly fourfold by 1955 if the goal of 1 public health nurse per 2,000 population and 1 supervisor (including special consultants) per 9 staff nurses is to be attained. No State has yet reached the ratio of 1 nurse to 2,000 population which for many years has been recommended by the National Organization for Public Health Nursing. Some of the New England States, which have ratios of 1 to 3,000 or 4,000, come the nearest to this ratio.

Although the public health committee of the procurement and assignment service and the administrative practice committee of the American Public Health Association have recommended that there be at least 1 public health staff nurse to each 5,000 of the population, 39 States have more than 5,000 persons per staff nurse. It is clear that there will need to be a marked expansion after the war in the number of staff nurses and accompanying supervisors if we are to have what competent authorities recommend as a desirable ratio of nurses to population.

POSTWAR GOALS

By 1955, we shall need 74,000 staff public health nurses, of whom about 25,000 should be qualified public health nurses, and 8,200 supervisors. This means that about 3,000 public health nurses per year will need to be trained, allowing for withdrawal from the profession at the rate of about 6 percent per year.

NEED FOR FEDERAL AID

There is reason to believe local governments may not be able to pay for the much larger number of public health nurses that will be needed to carry out the postwar health programs. Furthermore, since 1939 the number of such nurses employed by nonofficial health agencies has been gradually declining. The Annual Census of Public Health Nursing in 1944 showed that less than 5,000 of the 20,000 nurses in this field were employed by voluntary (nonofficial) agencies. It is assumed that, if the public health nursing strength of the country reaches 82,200 (74,000 staff plus 8,200 supervisors), at least 75,000 of them will be paid from tax funds, either local, State, or Federal.

At present, State and local health departments and boards of education are paying for about 15,000 nurses. If these agencies cannot secure appropriations to pay for any material increases in the number of nurses, it would appear that Federal funds will be needed to supply salaries, traveling expenses, and equipment for some 60,000 additional nurses (54,000 staff and 6,000 supervisors) by 1955 and for smaller numbers in intermediate years. Furthermore, it seems likely that Federal aid will be required for the education of 3,000 nurses a year to fill the public health nursing positions that will develop after the war. This Federal support should be given in the form of grants-in-aid to State health departments.

BEDSIDE NURSING CARE A PROPER FUNCTION OF PUBLIC HEALTH NURSING SERVICE

For the past 3 years the Public Health Service has been urging State and local health departments to include in their programs more bedside nursing care for the sick in their homes. Two years ago, the State and Territorial health officers passed a resolution stating that bedside nursing care is a proper function of a generalized public health nursing service and that it should supplement, not replace, the services usually rendered by public-health nurses.

While there has been this official endorsement of nursing care of the sick as a legitimate health department activity, only a few State health officers have encouraged local health departments to develop this type of service. Among the cities which have included the nursing care of the sick as a regular function of the health department nurses are Savannah and Augusta, Ga.; New Orleans, La.; and Montclair, N. J. Seattle, Wash., has combined all its public health nursing services under the health department and is including bedside nursing care as one of its major functions.

INABILITY OF RURAL HEALTH DEPARTMENTS TO OFFER BEDSIDE NURSING CARE

Few rural health departments have offered this type of service because practically no rural health department has had a sufficent number of nurses to attempt such a service. Kitsap County Health Department in Washington (Bremerton Navy Yard area) began such a service a year ago. This service was made possible by the Red Cross which furnished several additional nurses. However, even with the additional nurses furnished by the Red Cross, the population per nurse in this area is 15,000 whereas the ratio should be 1 nurse to 2,000 population if the bedside nursing program is to be carried in addition to the usual preventive nursing activities.

POSTWAR UTILIZATION OF GRADUATE NURSES NOW IN WAR SERVICE

When the war is over, there will be available an unprecedented number of graduate nurses in this country. There will not be too many nurses in terms of the need for nursing care, but unless there is a carefully laid plan for the utilization of the services of these nurses as they are released from war duty there will be widespread nurse unemployment. On the other hand, inclusion of bedside care as a regular activity of every local health department would utilize the services of at least 45,000 additional nurses. It is important to realize now that returning veteran nurses who have not had public-health training and senior student nurses (cadets) will be able to find a place in this program even though they are not specially trained for this type of work. Not all staff nurses need to be fully qualified public-health nurses; it is sufficient if 1 in 3 is so qualified.

NEED FOR DEMONSTRATIONS

Nursing care for the sick is one of the services recognized by appropriating bodies as a commodity worth buying. When such a service has been demonstrated effectively, it will have unlimited community support. However, a demonstration is essential, first to convince the health administrators that good nursing care in illness reduces morbidity and mortality rates, and second, to teach the citizens that they may expect such service from a tax-supported agency.

NATION-WIDE POSTWAR NURSING PROGRAM

The subcommittee on local health units of the committee on administrative practice of the American Public Health Association, has proposed a scheme for health service coverage for the entire Nation. This plan is based upon units of not less than 50,000 population for each health district. Under this proposal, 1 nurse per 5,000 population is recommended (exclusive of supervisory personnel) for the usual health department nursing services exclusive of bedside nursing services. (The ratio is 1 nurse per 2,000 population if bedside nursing service is included.)

PROPOSED POSTWAR DEMONSTRATIONS

In order to demonstrate the value of including nursing services in a generalized health service program and to ascertain the costs of such an expanded service as well as the most economical methods for its provision, the recommendation is made:

1. That four rural health departments in different sections of the country be selected where the present organizational set-up and staff are in accordance with American Public Health Association standards.

2. That a sufficient number of nurses be added to maintain a ratio of 1 nurse to 2,000 population. Senior cadet nurses and returning veteran nurses who have not had special public health preparation could be used for this purpose as "assistant nurses" in the ratio of two assistants to one qualified public health nurse.

3. A team of nursing service analysts consisting of one full-grade public health nursing consultant, one associate statistician and two clerk-stenographers should be provided to help plan the demonstration, evaluate the service given, study the disease incidence, hospitalization facilities, and need for home nursing care in each community. Some of the questions to which the nursing service analysts should find answers would include:

(*a*) At what point does home nursing care of the sick cease to bring public health returns and become a "luxury service" for the mere convenience of the citizens?

(*b*) What type of personnel is necessary to render this service? Do all of the nurse assistants need to be graduate nurses?

(*c*) Where adequate hospital facilities are available and hospital insurance schemes bring that service within the reach of all, will the need for home nursing care decrease?

(*d*) How may a service of this type be publicized so that it will be utilized effectively?

(*e*) How much nursing supervision must be provided to insure a high quality of service?

(*f*) Should tax-supported bedside nursing care in the homes be available for all economic groups of the population?

CONTINUING NEED FOR PRESENT NURSE EDUCATION PROGRAM

The present nurse education prgoram, which is designed to "assure a supply of nurses for the armed forces, governmental and civilian hospitals, health agencies, and war industries," should be continued after the war though at a lower recruitment rate. The magnitude of the program is now determined by the practicable quota of annual admissions to nursing schools. The quota of admissions, although based on the best estimates of need during the fiscal year 1945–46, would leave an unmet nursing need of approximately 29,200 nurses. The end of the European war will affect the needs for nurses only in respect to the assignment of nurses to the military services in Europe. Some of the nurses released there will be assigned elsewhere. The number of nurses made available through gradual demobilization after the end of the European war will not cover the known unmet need. Therefore, no downward adjustments in the training program for nurses under the Bolton Act should be made until the end of the entire war.

The need for postgraduate training grows more acute as the Army and Navy withdraw graduate nurses from the civilian reserve. The annual inflow to the pool of nurses with special preparation must be stepped up to cover these losses and known shortages. The shortages are particularly acute in psychiatric nursing, public health nursing, and in the fields of teaching, supervision, and administration in nursing schools and nursing services, including care of veterans.

NEW PROGRAM SHOULD BE INITIATED IN FIRST POSTWAR YEAR

Immediately after the war, the nurse education program should be modified to meet the needs of peace. If a more adequate health program is to be developed in this country and a more vigorous attack is to be made on such major problems as tuberculosis control, the study of nervous and mental disorders, and the better distribution of hospital and medical care services, then the education of nurses must proceed at a pace adequate to meet the needs of the country.

POSTGRADUATE PROFESSIONAL PROGRAM

Sufficient graduate nurses to meet the needs for nurses with special preparation in nursing schools and nursing service including public health nursing services will not have been prepared through the wartime program. Nurses graduated after the close of the war will continue to need these special types of preparation. The number of nurses needed to give standard public health nursing service to all people is approximately 65,000, and while not all communities will at once achieve this standard, the current number of public health nurses (20,000) will expand markedly as nurses with this special preparation become available. Only 29 percent of the nurses now in the field have had one or more years of special study. Preparation for their work on the part of the large remaining percentage would be reflected in improved community health.

In nursing schools approximately 20 percent of all instructional positions were vacant in November 1943 and the percentage has since increased. A large proportion of filled positions is occupied by inexperienced nurses without special preparation for important posts on this production front.

Approximately 15,000 additional graduate nurses would have to secure special preparation in psychiatric nursing if patients with mental illnesses (more than half the total patients in the Nation's hospitals) were to receive standard care (1 nurse to 25 patients).

The care of veterans in mental and general hospitals will require more nurses with special preparation in psychiatric nursing and rehabilitation techniques.

These major shortages will necessitate more rapid expansion of facilities for specialization and assistance to graduate nurses seeking opportunity for special preparation.

New features of nursing service should be injected into this preparation, such as preparation for direction of practical nurses, preparation for nursing in the hospital community health center, preparation of instruction of student nurses in the evolving concepts of nursing, including emphasis on prevention, global aspects due to world-wide transportation, etc.

BASIC PROFESSIONAL PROGRAM

The demands made upon the nurse serving in the hospital and community are changing to include nursing in the hospital health center, direction of a group of supplementary nursing personnel (practical nurses), the teaching of mental and physical health, and control of communicable diseases, icluding those introduced through global transportation. With this type of nursing, all citizens may reach their optimum level of effectiveness. To train nurses to fill these new demands, schools of nursing must adopt new measures. At the same time they must receive subsidy to operate modified training programs and to demonstrate the value of this type of nurse and public servant.

VOCATIONAL NURSE TRAINING—PRACTICAL NURSES

Experience with paid and volunteer auxiliary nursing service during the war has further demonstrated the feasibility of the use of less highly trained personnel for certain aspects of nursing care. The vocational or practical nurse can be trained to furnish less expensive care, and in combination with the highly trained professional nurse will provide total health care of high standard. The preparation of the practical nurse should be designed to promote thorough training and to prevent overproduction and exploitation of the student. Only a few schools for this type of training now exist. This new type of education cannot proceed on a sound basis without financial assistance.

Clinical Dental Services

ORGANIZATION OF THE DENTAL CORPS OF USPHS

While the Medical Corps of the Public Health Service is probably the oldest of the governmental medical agencies (established 1798, commissioned corps, 1889), its Dental Corps is the youngest of the three commissioned corps. It was not until April 9, 1930, that provisions were made for commissioning dental officers in the Regular Corps of the Public Health Service. Between 1918 and the passage of the 1930 act, dental service to Service beneficiaries was rendered largely by Reserve Corps officers on extended active duty.

The original complement of dental officers commissioned in the Regular Corps in 1930 was 26. Today there are on active duty 60 dental officers of the Regular Corps, 307 Reserve officers, and, in addition, 25 dentists serving their internship in United States marine hospitals.

In 1951 it is anticipated that in the Public Health Service there will be approximately 200 dental officers in the Regular Establishment with about 75 additional Reserve officers on extended active duty.

DIVISION OF DENTISTRY

The recently approved Public Health Service Act, Public Law 410, Seventy-eighth Congress, carried over previous legislation creating the rank of Assistant Surgeon General (dental) on the staff of the Surgeon General, United States Public Health Service. In the reorganization order of December 1, 1943, the Surgeon General established a division of dentistry directly responsible to him with the duty of coordinating all activities for the recruitment, placement, and training of dental officers and for the coordination of all dental activities within the Public Health Service.

At the beginning of hostilities there were on active duty in the Public Health Service approximately 100 dental officers, divided about equally between the Regular Corps and the Reserve Corps. Today there are 367 dental officers and 25 dental interns distributed among 183 stations. In addition thereto, there are 110 contract dental surgeons giving full- or part-time service located generally where the demands for dental service are too small to justify the assignment of a commissioned officer.

DENTAL WORK OF SERVICE

The dental work of the Service is broadly divided into three divisions: Clinical, public health, and research.

Most of the dental officers naturally are assigned to clinical duties, although at present there are eight officers devoting full-time service to research and six to public health.

The Public Health Service has a widely diversified group of beneficiaries. They are: (1) Seamen of the merchant marine and War Shipping Administration vessels of United States or foreign registry and other legally designated seamen; (2) Coast Guard and Coast and Geodetic personnel; (3) lepers; (4) United States Employees' Compensation Commission beneficiaries; (5) Public Health Service officers and employees; (6) Immigration and Naturalization Service (persons detained thereby); (7) special-study cases; (8) pay patients (dependents of certain legal beneficiaries; Veterans' Administration beneficiaries; Army, Navy, and Marine Corps personnel; enemy alien detainees, and others).

CLINICAL WAR SERVICES

With the advent of war special emphasis was placed on the care of beneficiaries of the United States Coast Guard, Maritime Training Service, and the merchant marine. In order to relieve, at least in part, the urgent need for dental services among these beneficiaries, 20 dental officers were assigned to sea duty and 12 to stations beyond the continental limits of the United States.

During the past fiscal year dental treatment was rendered to 426,038 beneficiaries by dental officers assigned to the following services: United States Coast Guard, PHS Bureau of Medical Services, included in which are the Maritime Training Service, Marine Hospital Division, Federal Penal and Correctional Institutions, Mental Hygiene Division, Venereal Disease Control Division, and Farm Security Administration. These 426,038 patients received a total of 1,931,226 treatments.

In contrast, the 1940 annual report showed 355,109 treatments rendered to 110,303 beneficiaries by 54 full-time dental officers and 38 interns.

POSTWAR PLANNING

Postwar planning with respect to the clinical side of the Public Health Service dental service is seemingly tied up with the postwar strength of the Coast Guard and the merchant marine, the two groups furnishing a large majority of its patients. Considerable thought is being given to the further development of dental trailers and portable equipment for the care of beneficiaries located in isolated regions, requiring certain of the clinics in the older marine hospitals, and improvement in the scope and type of training given during the dental internship.

SANITARY ENGINEERING

NEED FOR A SANITARY ENVIRONMENT

The foundation of all health work is a sanitary environment, one as free from disease and abnormal conditions as modern science can make it. Pure water supplies should be available to the entire population. Public water supplies are generally taken for granted in our cities, yet even here there are appalling deficiencies. Rural areas for too long have depended on water supplies from unprotected wells and surface waters. The problem of disposal of wastes in urban and rural areas has not yet been solved although the methods are known. Inertia, indifference, and unwillingness or inability to finance sewer systems in metropolitan areas and the construction of sanitary privies in rural areas, still leave large segments of the population at the mercy of water-borne diseases. While pasteurization of milk is now accepted as a standard precautionary measure, some milk supplies are still without this protection. Finally, there remain certain control measures required to protect the country against outbreaks of plague, typhus, and malaria, such measures requiring the supervision of sanitary engineers.

POSTWAR PROGRAM

The proposed postwar sanitation program would normally take 20 years for the construction of sewers and the development of new water systems. It is here suggested that activities may be speeded up and that a considerable part of the program be completed in 10 years. If the whole of the public water supply, sewerage, and rural sanitation programs were spread over 20 years, and it be assumed that construction would proceed at a uniform rate, the Federal program for grants-in-aid would stay at a stable level of $163,000,000 annually. However, if the program for improvement of existing water supplies, which would cost about one-half a billion dollars, were to be speeded up and placed on a 5-year instead of a 10-year basis, then Federal expenditures would average $187,000,000 for the first 5 postwar years and only $139,000,000 for the second 5 postwar years. This policy would result in a tendency, which is anticipated in other construction programs, to throw the weight of activity into the years immediately after the war and then to taper off. There are important employment implications in this method of handling the major construction programs.

SANITATION FACILITIES NEEDS

Surveys of need, made by States and in some cases by smaller jurisdictions, are here set forth in the National Inventory of Sanitation Needs. Costs, methods of financing, the recommended amount of Federal participation, and a construction time schedule are included in the several papers which follow.

Public Health Methods

MORBIDITY AND MORTALITY STATISTICS

The Division of Public Health Methods includes two major activities: (1) Collection, analysis, and publication of morbidity and mortality statistics, and (2) public health education. Statistical functions include the planning and making of field surveys of health needs, as for example, the National Health Survey, and the study of health personnel needs as indicated by the distribution of physicians, dentists, nurses, and other health personnel in relation to population density. Sickness and disability rates are studied on a sample basis for different social, occupational, and economic groups. Causes of death are similarly analyzed.

In addition to these broad statistical studies, which are based on field surveys for the most part, the Division is also responsible for the collection of current morbidity and mortality statistics from States and localities and from foreign countries. These are published weekly in Public Health Reports and are further amplified through analytical studies of particular statistics relating to specific diseases or localities. Thus, the statistics for incidence of cancer may be analyzed with a view to interpreting trends or statistics on mortality rates, collected by the Bureau of the Census, the Metropolitan Life Insurance Co., and other collecting agencies or groups, may be studied in connection with the changing age and sex composition of the population. Such studies are needed to show where emphasis should be placed in developing programs for the improvement of the Nation's health. As morbidity and mortality rates decline for one disease that has been conquered, the rates for other diseases and conditions which still baffle science move into positions of prominence indicating the points at which stronger organized attacks should be directed.

HEALTH EDUCATION

The second major activity of the Division of Public Health Methods is that of health education which includes the use of various media for the dissemination of education and informational material to the public. While health education is one of the functions of local health departments, it differs from such services as tuberculosis control and public health nursing inasmuch as the chief burden of these activities falls on local personnel whereas the chief responsibility for preparation of the materials used in health education must perforce reside in a Federal agency.

THE ROLE OF THE PUBLIC HEALTH SERVICE IN HEALTH EDUCATION

The Public Health Service is in a position to prepare, or to arrange for outside experts to prepare, radio scripts, movies, magazine articles, newspaper releases, and technical publications for use by State and local health authorities, by other official and voluntary groups, and by industry, labor, agriculture, and the general public. In this field, then, the Federal Government should provide more than consultative services to States and localities. It would be beyond the financial ability of practically all jurisdictions, save the Federal, to employ the experts required to prepare educational material. Likewise it would be wasteful for each State to undertake such preparation at its own expense when a single agency could do the job for all States and could act as a central distributing unit.

In addition to furnishing material through the usual media for mass publicity on new public health developments of national scope, the Federal health education functions should include evaluation of programs and materials; experimental demonstrations in the field; consultation service to States on programs, personnel, and materials; assistance to States and to the Public Health Service in developing in-service training programs; assistance to States in the preparation of educational materials; development of a central clearing house on new developments and materials; and establishment of an information service and public relations unit for the Public Health Service.

LOCAL ORGANIZATION

At the local level an adequate program of health education to serve both school and adult populations in every community requires the services of a health educator trained in both public health and education. Such an individual will coordinate the activities of schools, health departments, and voluntary agencies in a community welding them into a total health educational program. The health educator may be employed by the local health department, the education department, or by the two departments jointly.

STATE ORGANIZATION

At the State level there would be needed a health education unit the functions of which would be the establishment of broad State policies, advisory consultant service, and the provision of necessary materials for the use of public health personnel throughout the State.

TRAINING OF PERSONNEL

The immediate need in the postwar period will be the training of personnel. At present there are not over 150 thoroughly trained personnel in the field, i. e., persons who meet the qualifications laid down by the committee on professional education of the American Public Health Association. Experience has shown that it takes approximately $2,000 to train one individual. To train 1,500 local workers and advisory personnel would require $3,000,000. This amount should be spread over a 10-year period to avoid undesirable sudden expansion.

DISTRIBUTION OF COSTS

It is estimated the over-all cost for the State and local program here outlined would be approximately $8,000,000 annually. Most of this cost would be met by local official and voluntary funds augmented by Federal grants-in-aid for generalized health programs or for specialized activities, such as tuberculosis control, maternal and child health, venereal disease control, etc. Thus the items to cover Federal expenditures for health education are distributed in the budgets of various divisions of the Service. To recapitulate, the total program would cost $12,800,000 annually from all sources distributed as follows:

Estimated annual expenditures for health education, by source of funds

Type of expenditure	Total cost	Federal construction
Total	$12, 808, 000	$2, 136, 000
Health education in the Public Health Service	500, 000	500, 000
Training (over a 10-year period)	300, 000	300, 000
Health education division in State health departments	4, 008, 000	[1] 1, 336, 000
Health educators in local communities	8, 000, 000	0

[1] Grants-in-aid under title VI and from special appropriations for tuberculosis control, etc.

NATIONAL INSTITUTE OF HEALTH

1. Office of the Director.
2. National Cancer Institute.
3. Division of Infectious Diseases.
4. Division of Physiology.
5. Biologics Control Laboratory.
6. Chemistry Laboratory.
7. Pathology Laboratory.
8. Zoology Laboratory.
9. Industrial Research Laboratory.

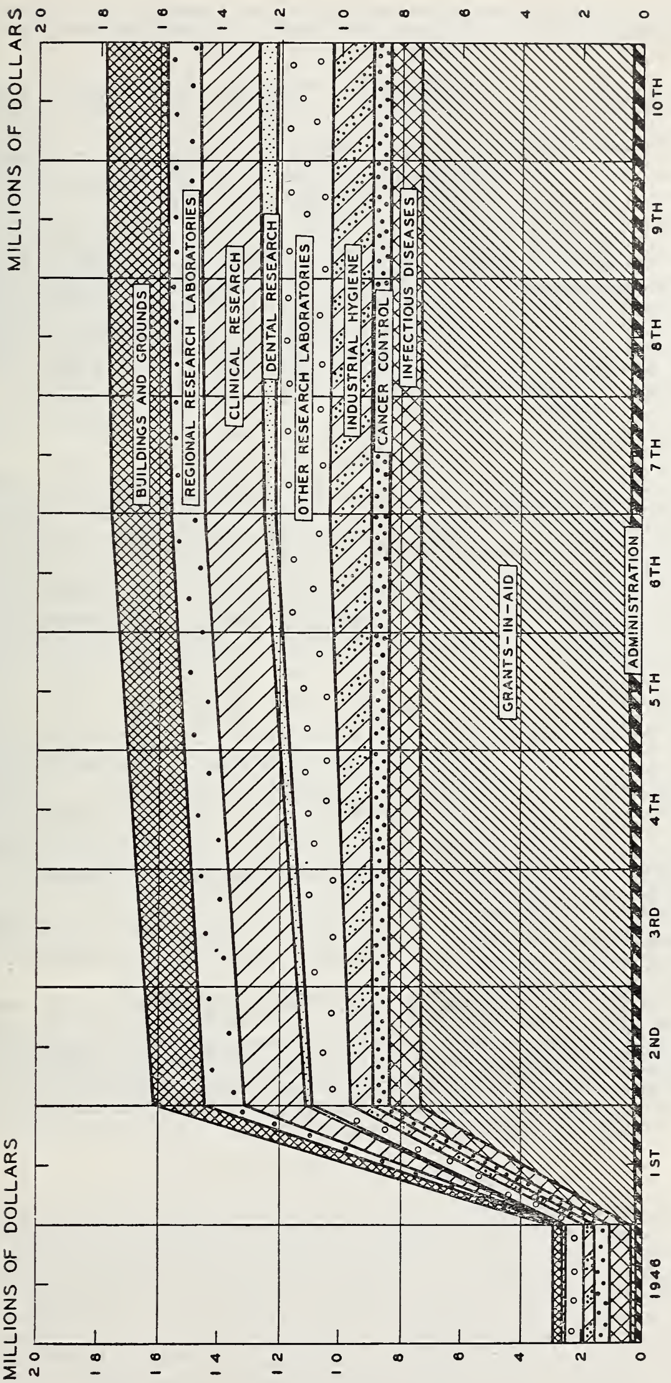

MILLIONS OF DOLLARS
0
2
4
6
8
10
12
14
16
18
20
1946
1ST
2ND
3RD
4TH
5TH
6TH
7TH
8TH
9TH
10TH
BUILDINGS AND GROUNDS
REGIONAL RESEARCH LABORATORIES
CLINICAL RESEARCH
DENTAL RESEARCH
OTHER RESEARCH LABORATORIES
INDUSTRIAL HYGIENE
CANCER CONTROL
INFECTIOUS DISEASES
GRANTS-IN-AID
ADMINISTRATION

Exhibit H.—*Postwar budget and personnel requirements of the National Institute of Health, fiscal year 1946, and first, sixth, and tenth postwar fiscal years*

Division	Fiscal year ending June 30, 1946		First postwar fiscal year		Sixth postwar fiscal year		Tenth postwar fiscal year	
	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget
Total budget		$2,798,751		$16,048,931		$17,504,163		$17,696,183
Total operating expenses		2,607,751		8,902,931		10,358,163		10,550,183
Total grants-in-aid		191,000		7,146,000		7,146,000		7,146,000
Total personnel	803		2,916		3,404		3,444	
Administrative office	70		130		130		130	
Operating expenses		163,510		289,310		289,310		289,310
Grants to universities for research		100,000		7,000,000		7,000,000		7,000,000
National Cancer Institute	112		140		140		140	
Operating expenses		379,120		463,120		463,120		463,120
Grants to hospitals, etc., for research		91,000		146,000		146,000		146,000
Division of Infectious Diseases	199		268		268		268	
Operating expenses		666,796		955,400		1,011,500		1,011,500
Division of Physiology (exclusive of Dental Division)	84		239		303		303	
Operating expenses		322,732		777,732		1,002,732		1,002,732
Dental Division (now under Division of Physiology)	19		62		110		150	
Operating expenses		83,860		175,660		377,980		570,000
Biologics control laboratory	23		27		27		27	
Operating expenses		107,983		127,623		127,623		127,623
Chemistry laboratory	18		24		40		40	
Operating expenses		64,527		81,947		143,255		143,255
Pathology laboratory	16		47		47		47	
Operating expenses		52,805		136,660		136,660		136,660
Zoology laboratory	29		52		90		90	
Operating expenses		82,235		163,675		325,670		325,670
Industrial hygiene research laboratory	116		190		395		395	
Operating expenses		399,054		699,054		1,437,434		1,437,434
Buildings and grounds—custodial personnel only	117		631		748		748	
Operating expenses		285,129		1,745,790		2,030,919		2,030,919
New 500-bed medical center hospital			443		443		443	
Operating expenses other than custodial				1,309,600		1,309,600		1,309,600
New institute and hospital for study of nervous and mental diseases			239		239		239	
Operating expenses other than custodial				643,040		643,040		643,040
Regional research laboratories:								
Plague suppressive measures laboratory			106		106		106	
Operating expenses				308,580		258,580		258,580
Malaria laboratory			106		106		106	
Operating expenses				308,580		258,580		258,580
Other tropical-diseases laboratory			212		212		212	
Operating expenses				717,160		542,160		542,160

The National Institute of Health

HISTORY OF THE INSTITUTE

In August 1887 a laboratory of hygiene was established in a single room of the Marine Hospital at Stapleton, Staten Island, N. Y. Here the Public Health Service undertook its first work in bacteriology. Four years later the laboratory was moved to the headquarters of the Marine Hospital Service in Washington, D. C. Early experiments were connected with quarantine work and with the study of cholera, tuberculosis, malaria, typhoid fever, pneumonia, and other diseases encountered by the Service in carrying out its statutory responsibilities. By 1903 research activities of the hygienic laboratory had so expanded that an entire building was made available for this work. Other buildings were added. The name of the institution was changed by an act of Congress (May 26, 1930) to the National Institute of Health.

In 1938 the institute was transferred to Bethesda where there are now six buildings to house the National Cancer Institute, the Division of Infectious Disease, the Laboratory of Industrial Hygiene Research, the various other laboratories for research in chemistry, zoology, pathology, and biologics control, and the administrative services.

FIELD RESEARCH ACTIVITIES

Important public health research is also conducted in field laboratories. Since the first outbreak of plague in San Francisco a laboratory for plague suppressive measures has been maintained in that city. Similarly a laboratory for the study of Rocky Mountain spotted fever and other diseases was established at Helena, Mont., and a laboratory for the exclusive investigation of stream pollution and sewage disposal has been in operation at Cincinnati for many years. Research work on leprosy has been conducted at Honolulu, the island of Molokai, and the leprosarium at Carville, La. These activities are under the supervision of the director of the institute.

POSTWAR EXPANSION

All the existing laboratory facilities of the institute are in need of expansion to provide room for research in the basic sciences, in new fields of medicine, and in fields not now being explored sufficiently. In addition, there is great need for clinical research in conjunction with laboratory research. For this purpose it is proposed to construct a 500-bed medical center hospital and a 200-bed neuropsychiatric institute and hospital on the institute grounds. In the first of these hospitals studies will be made of patients suffering from nutritional deficiencies, the degenerative disease of middle and later life, infectious diseases, and other conditions of public health interest. In the neuropsychiatric institute researches will be conducted to determine the causes of mental and nervous disturbances and possible therapeutic measures to relieve or prevent such conditions.

GRANTS-IN-AID FOR SCIENTIFIC RESEARCH

For the fiscal year 1946 the sum of $91,000 has been requested for cancer grants-in-aid and $100,000 for other public health research grants. Authority for research grants other than cancer has just been given by the Congress (Public Health Service Act of 1944, Public Law 410), and it is planned that this work will be conducted on a small scale until the war in Europe is terminated.

VALUE OF RESEARCH GRANTS-IN-AID

The value of this method has been successfully demonstrated by the National Cancer Institute, by the Office of Scientific Research and Development, and by outside institutions, and it is felt that the greatest public health advancement can be made in research by the rapid expansion of the grants-in-aid procedures, as soon as scientific personnel becomes available in the universities and other research institutions. An estimate is made of $7,000,000 per annum for these grants beginning in the first postwar year. In accordance with the authority granted in Public Law 410, the grants will be made only for research projects recommended by the National Advisory Health Council after thorough investigations of the projects have been made, and they will be administered under regulations similar to those now in force under the National Cancer Institute Act.

Exhibit I.—*Proposed new construction, extension of existing facilities, replacements, repairs, etc., for the National Institute of Health, first postwar fiscal year*

(Detail for item B 1 in exhibit A)

[In 1943 dollars]

Type of facility:		Estimated cost
Total		$23, 363, 827
(a) New 500-bed medical center hospital and housing facilities		6, 195, 000
(1) 500-bed hospital	$5, 180, 000	
(2) Nurses' home	845, 000	
(3) Interns' home	170, 000	
(b) New institute and hospital for study of nervous and mental diseases		4, 500, 000
(c) New construction for dental research		1, 019, 020
(d) New construction for industrial hygiene research		732, 320
(e) New construction to provide additional space for existing and postwar research (projects not specifically mentioned elsewhere) and for training scientific personnel		2, 456, 200
(f) Miscellaneous: Virus and infectious diseases unit, animal breeding unit, boiler plant and maintenance shops, utility buildings, cafeteria, laundry, etc		2, 919, 635
(g) Housing facilities		1, 447, 460
(1) 12 duplex quarters and 2 apartment houses, each apartment house to house 35 families	$1, 343, 300	
(2) Quarters for chief mechanics	34, 160	
(3) Quarters for laboratory at Hamilton, Mont	70, 000	
(h) Repairs, alterations, etc., to improve existing facilities		422, 192
(i) Acquisition of additional land at Bethesda, Md., for National Institute of Health		250, 000
(j) Regional research laboratory buildings and facilities needed by National Institute of Health in the field (site acquisition not included)		3, 172, 000
(1) Plague suppressive measures laboratory	$690, 000	
(2) Malaria	600, 000	
(3) Other tropical diseases	1, 882, 000	
(k) Acquisition of land for regional laboratories in San Francisco ($175,000) and in Memphis ($75,000)[1]		250, 000

[1] Provisional estimate; further study of site requirements and costs needed.

The National Cancer Institute

NATIONAL CANCER INSTITUTE CREATED IN 1937

In 1937 the National Cancer Institute was created by act of Congress. Constituting one of the major divisions of the National Institute of Health, it is housed in a separate building and has its own director. The act empowers the Surgeon General, in cooperation with a National Advisory Cancer Council, to:

1. Conduct, assist, and foster research.
2. Provide training and instruction in the diagnosis and treatment of cancer.
3. Provide research fellowships in the institute.
4. Secure for the institute consultative services and advice of cancer experts from the United States and abroad.
5. Cooperate with State health agencies in the prevention, control, and eradication of cancer.
6. Procure, use, and lend radium to other agencies and institutions.

NATIONAL ADVISORY COUNCIL

The National Advisory Cancer Council, created under the same act, is authorized to:

1. Review research projects or programs submitted to it or initiated by it, relating to the cause, function, or methods of diagnosis and treatment of cancer.
2. Collect information and make it available to scientists and the public.
3. Review applications for grants-in-aid for research and to certify to the Surgeon General its approval of grants for such projects as show promise.

STATE DIVISIONS OF CANCER CONTROL

At the present time 14 of the States have full-time divisions of cancer control. In three of these States (Missouri, New Hampshire, and Vermont) the law is administered by cancer commissions; in 10 (Alabama, Connecticut, Georgia, Illinois, Maine, Massachusetts, New York, Rhode Island, South Carolina, and West Virginia) by the State department of health; in 1 (Texas) by the State university.

REQUISITES OF A STATE CANCER CONTROL PROGRAM

A complete State cancer-control program usually provides for:

1. The establishment of tumor clinics or hospitals for the diagnosis and treatment of cancer.
2. Reporting of cancer cases by physicians, hospitals, and pathological laboratories to the division of cancer control.
3. A system of follow-up of cancer cases.
4. Pathological laboratories for tissue diagnostic service.
5. Statistical and epidemiological records of case reports, death reports, and pathological laboratory reports.
6. Dissemination of information about cancer to physicians and to the public.

THE ROLE OF THE FEDERAL GOVERNMENT

The attack on the cancer problem requires the combined efforts of many men trained in many different branches of the basic sciences of biology, chemistry, and physics. The solution of the problem is not a one-man, or one-institution, job. Insofar as the Federal Government is concerned, it appears that much may be accomplished through the appointment of cooperative committees selected from members of the various cancer research foundations, and from various other institutions that are actively engaged in cancer control, prevention, therapy, and research. Working cooperatively with these committees, the Cancer Institute is able to pursue the attack on the cancer problem through:

1. Education of the public.
2. Postgraduate education of physicians in the diagnosis and treatment of cancer.
3. The loan of radium to hospitals and tumor clinics.
4. Assistance to States to enable them to set up full-time departments of cancer control in the respective State boards of health.
5. Advice and guidance to universities and medical schools desiring to establish departments of oncology or cancer biology.
6. The establishment of prevention and case-finding clinics.
7. Grants-in-aid to various institutions and individuals for cancer research.
8. Promotion of conferences on the several phases of the cancer problem.
9. The continuation of long-time cooperative studies in the fundamentals of cancer biology.

Current Cancer Research Activities [1]

COMPOUNDS INCITING CANCER

No other form of human maladjustment on the physical level has such a large number and variety of inciting agents, both chemical and physical, as cancer. Excluding from consideration the well-established part played by X-rays and other rays in the genesis of cancer, there is now a total of 1,028 compounds which have been tested for carcinogenic (cancer generating) potency of which 284 were reported to be active.

---

[1] Excerpts from Barnard lecture to be given by R. R. Spencer, chief, National Cancer Institute, at St. Louis, Mo., on November 21, 1944.

OCCUPATIONAL AND HABIT CANCERS

Cancer in human beings is to a considerable extent an environmental and occupational disease. Modern industry has created for man a new artificial environmont which has brought with it a large number of industrial and environmental hazards affecting nearly every organ of the human body. Occupational cancers are elicited by a great variety of chemical and physical agents, such as arsenic, radium, crude mineral oil, pitch, tar, soot, creosote, to mention a few. Habits, too, are responsible for cancer of the mouth, lips, and cheeks in tobacco smokers and for cancer of the skin of the abdominal regional in carriers of certain heating appliances in Kashmir or in Japan.

INCREASING FACTORS IN GENESIS OF CANCER

The continued increase in cancer prevalence during the past three or four decades cannot be accounted for solely on the basis of better recognition of the disease, or on improved diagnostic methods, or even on the fact that there are more people living now to the cancer age. Cancer following X-ray burns, for instance, could not have existed prior to the discovery and use of these rays, nor could watch-dial painters have contracted occupational osteosarcoma from radium prior to the use of this substance. Increase of cancer of the lung in recent years may be due to city soot or to the exhaust gases from automobiles, or both.

NO METHOD KNOWN TO STOP CARCINOGENIC PROCESS

Some of the agents which are known to be carcinogenic (i. e., capable of inciting the growth of cancer cells) induce the process in widely different species of organisms and in different tissues of the same species. Other agents are more selective and affect only certain tissues. Whatever the inciting agent may be and however selective or nonselective it may be, the fact of primary significance is that nothing has ever been found which has given even a hint as to how the carcinogenic process, once started, may be stopped or reversed. Complete destruction of all cancer cells is at present the only known method of effecting a permanent cure of cancer.

PREVENTABLE CANCERS

Whenever a new cancer-inciting agent is discovered of the type mentioned (i. e., an agent that originates outside the organism, a so-called exogenous agent), the knowledge provides us at once with the possibility of being able to develop a practical means of protection against this particular agent. Therefore, all cancers induced by exogenous agents belong definitely in the category of preventable diseases.

CANCERS RESPONSIBLE FOR HIGH DEATH RATE

Unfortunately, the high death rate from cancer is not ascribable to cancers of exogenous origin, but rather to those of internal origin. Clinical and experimental evidence suggests that the majority of such cancers are induced by unusual, and for the most part, long-standing, internal environmental and biochemical imbalances. According to the 1942 census reports, cancer of the digestive organs and peritoneum (the membrane lining the abdominal walls), not including cancer of the oral cavity, accounted for 45.7 percent of all deaths from cancer. Cancer of the breast and of the female generative tract accounted for 43 percent of all cancer deaths among women. Certain of these internal cancers now thought to be due largely to endogenous conditions may be shown later to have extrinsic etiologic factors, i. e., they may appear to be due to internal causes but may actually be due to external causative factors.

COMPLEXITY OF ORIGIN OF SOME ENDOGENOUS CANCERS

It may now be stated that at least some cancers of endogenous origin are the resultant of a complicated set of internal factors—genetic, hormonal, and biochemical. Furthermore, the factors responsible for cancer of the breast do not necessarily bear any relationship whatever to the biochemical conditions responsible for cancer of the stomach, liver, lung, prostate, or other tissues. By the same token, it is apparent that a diagnostic test for cancer in one organ or tissue is not likely to be effective in detecting cancer in another organ or tissue. To be useful, a diagnostic test should detect the disease in its early stages.

DUAL APPROACH TO STUDY OF CAUSATION OF CANCER

In studying the causation of cancer two lines of research are necessary: (1) Study of the casual genesis of tumors, including the inciting agents leading to the development of malignancy; and (2) the formal genesis, or the factors responsible for the nature of the cancer cell and its tendency to unlimited multiplication. It is now clear that there are multiple and diverse casual conditions which probably vary for each type of cancer. Some investigators, indeed, go so far as to consider the different types as representing different diseases. But in the development of the cancer cell itself or the changes in the cell responsible for the malignant state, there appears to be no such diversity. For although the mechanism of the change is as yet unknown, it seems reasonable to believe that the pattern of the transformation from normal to cancer cells may be the same in all tissues.

CANCER AS A SURVIVAL PROCESS

In cancer we are observing unquestionably a movement toward that universal goal of all living things, survival. In the communicable diseases, the struggle for survival may end in the death of the host, the death of the parasite, the death of both, or a compromise by which both host and parasite live together in symbiosis. In cancer, by contrast, the local surviving cells do not assume their normal function following continued injury, but take on the properties of malignancy and become parasitic. The intracellular change culminating in cancer usually represents a process which requires a long period of time. Furthermore, the pathologist can detect no discontinuity between the precancerous and the cancerous process. Finally, in terminal stages, cancer tissue will continue to grow and increase in weight while the rest of the body rapidly loses weight.

Thus, while many of the attributes of the cancer cell have been ascertained the search for the secret of this type of cell must continue as one of the most important fields of experimental biology.

Infectious Diseases

LIMITATIONS OF PROPOSED RESEARCH

The investigations which it is proposed to make in the field of infectious diseases have been confined to ailments of social and economic importance to the people of the continental United States or to areas now under the sanitary control of this country or likely to come under such control after the war.

The subjects proposed for investigation have been selected largely with a view to practicability, especially to the gaining of fundamental knowledge that might prove of value in the control or treatment of the ailments considered.

An effort has also been made to keep the number of trained personnel to a minimum, for it is believed that there will be a marked shortage of physicians and trained laboratory investigators due to the partial interruption of educational programs during the war, to military casualties, and to increased demands for such persons occasioned by the desirable expansion of State and county health organizations, clinics, hospitals, and the like.

SPECIFIC INVESTIGATIONS

It is suggested that some 19 separate research projects be undertaken, most of them to be carried on at the National Institute in Bethesda, the others in field laboratories, especially at Hamilton, Mont., and in the new laboratories for tropical diseases when they become available.

INVESTIGATIONS AT BETHESDA

1. Epidemiology.
2. Rickettsial diseases, such as typhus fever, Colorado tick fever, and Rocky Mountain spotted fever.
3. Common cold.
4. Miscellaneous infections, such as measles, mumps, chickenpox, poliomyelitis, encephalitis, atypical pneumonia, influenza, etc.
5. Malaria-study of insecticides, malaria mosquitoes, chemotherapeutic agents, etc.
6. Tuberculosis.
7. Pneumonia.

8. Enteric diseases, such as typhoid fever, diarrhea of the newborn, etc.
9. Brucellosis—undulant fever.
10. Weil's disease—an acute infectious disease characterized by jaundice, fever, and enlargement of the liver and spleen.
11. Relapsing fever—an acute infectious disease marked by alternating periods of fever and lack of fever.
12. Mycology—the science and study of fungi.
13. Antibiotics—search for new types and improvement of known types.
14. Rheumatic fever.
15. Leprosy.

INVESTIGATIONS AT HAMILTON, MONT.

1. Tularemia—a disease of rodents, resembling plague, which may be transmitted to man.
2. Encephalitis—inflammation of the brain.
3. Rocky Mountain spotted fever.
4. Vaccines.
5. Selected studies (5).

ANNUAL TOTAL COST

The annual cost of these researches will be slightly under $1,000,000 in the first postwar year rising to about $1,000,000 in the tenth postwar year. The amount is infinitesimally small in comparison to the economic losses now suffered by society as a result of the diseases to be studied.

Division of Physiology

NEW FIELDS OF RESEARCH IN PHYSIOLOGY

The Division of Physiology will not only expand its present activities but will add a unit of clinical research and several field units to conduct nutritional studies and to carry on other research involving the study of conditions and diseases as they are manifested in human beings. This type of research goes beyond present laboratory activities. The postwar program of the Division of Physiology will be developed in three directions:

I. Clinical research in medical center hospital

There will be established a unit of clinical research to conduct studies on patients in the new medical center hospital. These studies will be concerned with (1) metabolic diseases, such as diabetes and conditions resulting from excessive activity of the thyroid gland or from entrance of poisons into the system through this gland; (2) the degenerative diseases, such as arthritis, heart diseases, and kidney diseases; (3) conditions resulting from abnormal composition of the blood, such as the anemias and conditions due to absence of granular cells from the bone marrow and the blood; and (4) dietary deficiency diseases. It is proposed that these studies involve the use of respiration chamber, very close supervision and control of food intake, frequent chemical analyses of blood and urine, and close study of the metabolism with a view to determining etiology, i. e., cause of the abnormal condition and establishing better methods of treatment and diagnosis.

II. Physiology

Eight units are planned for scientific laboratory research in connection with vitamins, therapeutic chemical agents, nutrition, the action of intestinal bacteria, the effects of synthetic drugs, and other chemical and physiological studies.

A. *Chemotherapy unit.*—This unit will be engaged in the synthesis and study of the chemistry of new chemotherapeutic agents similar to the sulfa drugs and penicillin with a view to finding substances active in diseases not amenable to present drugs, such as tuberculosis, virus diseases, etc.

B. *Chemical pilot plant.*—This unit is designed to furnish facilities for extracting and purifying large amounts of plant and tissue extracts. The institute has no such facilities at present and it is now necessary to try to secure such work in commercial plants. Liver extracts requiring a start with 1,000 pounds of liver is just one example.

C. *Biochemistry.*—The institute at present has no biochemical unit. There will be an increased need for biochemical work in the new medical center hospital. It is proposed that this unit would furnish biochemical service to other divisions of the institute not requiring full-time work in this field and would also concern itself with the isolation of new substances such as vitamins and with biochemical work in connection with other experiments in the Division of Physiology.

D. *Hormone research.*—There is now no organized hormone research in the institute. This important field needs more research. It is proposed that this unit would start in a small way with a view to developing important studies in this field. A start would be made by enlarging present investigations now in progress.

E. *Microbiological assays and research.*—Microbiological assay methods are becoming increasingly important. Additional work is already needed by this division, and it is proposed that new methods would be developed and more assay work done. This unit also would study the nutritive requirements of bacteria.

F. *Nutrition.*—This is an expansion of present activities to permit increased study of the dietary deficiencies which we are unable to undertake with present facilities.

G. *Sterile animal research.*—The importance of intestinal bacteria to the host is receiving increasing attention. Work done in this laboratory indicates that synthesis of essential substances by intestinal bacteria may play an important role in the welfare of the host. This subject should be studied intensively with sterile animals so that the intestinal flora can be controlled.

H. *Pharmacology.*—Present activities would be expanded to include studies of the mechanism of action and antidotes for new insecticides such as D. D. T. The action of synthetic drugs in tuberculosis and tissue metabolism in shock and drug action.

III. Field units

The field units would consist of four mobile laboratory units which would conduct field studies on the diagnosis, prevalence, and prevention of deficiency diseases in the population with a view to developing better methods of early diagnosis and prevention. They would also give service to State health departments in organizing nutrition surveys and instituting preventive measures.

Research In Oral Diseases

THREE FIELDS OF RESEARCH IN ORAL DISEASES

Research in oral diseases includes investigations into the cause, treatment, and control of all diseases originating in the oral cavity together with those oral manifestations characteristic of other general systemic diseases. Generally speaking, the diseases of the oral cavity include dental caries (tooth decay), periodontoclasia (pyorrhea), and various types of stomatitis (inflammations of gingival and other oral tissues). At present we have no knowledge as to the causes of many of these diseases and in most cases their treatment is entirely empirical. The discovery and development in the past few years of drugs and synthetic materials, especially plastics, has opened fields of investigation as to their use in treatment and repair of dental diseases. Only after careful study will it be possible to release or recommend many of these products for general use.

DENTAL CARIES

At present the major oral disease is dental caries. This disease affects 90 percent to 95 percent of our general population. The treatment of this disease or its sequelae requires about 75 percent of the available working hours of a profession numbering about 70,000 people. These professional man-hours are spent not on the total population but on about 25 percent of it. This 25 percent spends in the neighborhood of $500,000,000 per year for its service. The result of inadequate or no dental service on the remaining 75 percent of our population was well emphasized when the United States mobilized for war.

At present, little is known as to the cost of "rehabilitating" these "dental cripples," but the effect of reducing the number of the dental profession by Service demands becomes more evident as days go by. At persent we have the promise of controlling this disease and its sequelae by various methods. The practical application and general acceptance of these methods by the profession depends to a large extent on the results of research experiments to determine their efficiency. Only by markedly expanding the present research facilities for studies on dental diseases can we expect an answer to these problems within a reasonable period of time.

PYORRHEA

Next in order of importance of the diseases of the oral cavity, as far as prevalence is concerned, is periodontoclasia (pyorrhea). Whereas dental caries is principally a disease of childhood and early adult life, pyorrhea becomes prevalent usually after about 30 years of age. Unfortunately, this disease usually is more in evidence in those individuals who have had little trouble from dental caries. Once started, pyorrhea follows a continuously destructive course until there remains little or no supporting tissue for the teeth. The cause of this disease is unknown today; its treatment is expensive and time-consuming, and at best only slows down the destructive action. Our only hope to abate this disease for the future depends on research developments.

STOMATITIS—TRENCH MOUTH, CANKER SORES, AND OTHER INFECTIONS

The third major classification of oral diseases may be grouped under the general heading of "Stomatitis." In this group fall the more or less common oral diseases of Vincent's infection (trench mouth, Noma, aphthous stomatitis (canker sores), monilia infection (thrush), together with other oral manifestations of general systemic disturbances such as pregnancy, chronic metal poisoning, nutritional deficiencies, tuberculosis, and syphilis. As with other oral diseases mentioned above, the cause of stomatitis in most cases is unknown. Treatment generally speaking is empirical.

SIZE OF DENTAL PROBLEM

The enormity of the dental problem today may be visualized when it is realized that if the accumulated needs of the whole population were to be cleared up in 1 year it would require more than a fivefold increase in the number of dentists in this country; if only the annual increment were to be cared for, it would still be necessary to more than double the number of dental practitioners. The likelihood of resolving this problem along the lines of the traditional individual-patient-treatment basis does not seem promising. Our only hope lies in the future of research development which may be expected to cut down the need for dental services through discovery of means of preventing the more common oral diseases.

POSTWAR NEEDS FOR RESEARCH FACILITIES

Attention may be called to the fact that dentistry, like ophthalmology is basically an out-patient or clinical practice. With the exception of special studies in oral surgery, there is little need for any large number of hospital beds in connection with research studies. For research in the oral manifestation of systemic disease it is expected that such patients in their respective medical wards would be available for dental studies. In respect to oral tumors, benign and malignant, it is expected that such patients would be placed in the hospital wards assigned for such diseases and that these patients would be available for study. For this reason clinical research in oral diseases would require mainly space for a large dental clinic in the new medical research hospital together with laboratory and office space and only a small number (approximately 25) of available hospital beds.

For the postwar period the following program is presented. Since this program represents a considerable expansion over the present dental-research activities of the Service, it should be regarded more or less as an ultimate goal to be reached over a period of about 10 years. It is also suggested that part of this program be accomplished by grants-in-aid to existing dental-research activities in universities and nonprofit institutions outside the Service.

I. Dental-caries studies

A. Epidemiology

1. Broad epidemiological studies of the phenomena of dental caries in nature. Variations in prevalance reported specific for age, sex, and color. Consideration to geographic-geologic-climatologic factors, variation in water intake and general dietary, occupational, and other environmental influences, racial differences, habits of the population, and such other data as may shed light on the characteristics of dental caries as a mass phenomenon and point out broad determining factors in its prevalence or incidence.

2. Specialized local epidemiological studies of the physiological effects (i. e., health hazards) of fluorine in drinking water; metabolism of fluorine; and other studies dealing with social, economic, geographic, chemical, and other factors affecting dental caries.

B. Control of dental caries

1. Fluoride therapy.
2. Diet modifications.
3. Diet "medication"—natural or added anticaries agent.
4. Test of prenatal care (diet) assumption respecting increased resistance to dental caries attack.
5. Studies on treatment of dental caries with special emphasis on types of filling materials and various techniques.

C. Laboratory studies

1. Anatomy—pathology.
2. Physiology.
3. Bacteriology—mycology (the relation of the oral flora and their metabolic products to human and animal dental caries).
4. Biochemistry.
5. Animal experimentation.
6. Physics.

II. Oral bacteriology

Study of normal oral bacterial flora of man—the development of technics and culture media for the cultivation and classification of the oral flora.

III. Periodontal diseases

A. Epidemiology

A long-continued epidemiological study of selected general population groups embracing both individuals and household units. As the periodontal diseases have not been subjected to this type of study, some time will naturally be required for developing suitable methods for the investigation. When analyzed in relation to the particular circumstances prevailing in the populations studied, the various clinical manifestations of the several types of this condition may throw some light on either etiology or control. The purpose, therefore, of this study is to apply the principles of epidemiological inquiry to gingivitis and the diseases of the periodontal tissues. After developing acceptable mutually exclusive criteria of diagnosis, a few of the factors that might be considered epidemiologically are: Prevalence; age; sex; color; race; geographical distribution; climatological influence; seasonal variation; diet, past and present; details of local environment; personal habits; past history; dental, general.

B. Laboratory, experimental, and clinical studies

1. Periodontoclasia.
2. Alveolar atrophy.
3. Gingivitis.

IV. Ulcerative stomatitis

A. Epidemiology

1. Development of diagnostic criteria.
2. Prevalence.
3. Seasonal variation.
4. Characteristics in population according to age, sex, etc.
5. Influence of occupation.
6. Influence of diet (general).
7. Communicability.
8. Relation to oral hygiene, anomalies of eruption and alignment of teeth.
9. Site of attack in oral cavity.
10. Fatigue and general physical condition.

B. Bacteriology and biochemistry

1. Systematic study of technics and media for isolation of the oral spirochetes and their symbiones.
2. Thorough exploration of the influence of diet deficiencies (B_2 complex, vitamin C, etc.), diet supplements, etc.
3. Oral bacteriology in connection with epidemiological studies.
4. Relationship of abnormal blood compositions and of other pathologic conditions

C. Pathology

1. Gross and histo-pathological studies of the oral mucosa, gingivae, tonsils, pharynx, and supporting structures of the teeth during various stages of the diseases as they occur in monkeys and such other experimental animals as may be used.
2. Study of such human material as becomes available.

D. Evaluation of treatment and sequelae

V. *Other oral diseases*

A. Special studies on etiology and treatment of—

1. Tumors of the jaws and soft tissues.
2. Erosion of the dental tissues.
3. Oral manifestations of systematic diseases.

ZOOLOGY LABORATORY

POSTWAR NEED FOR RESEARCH IN MEDICAL ZOOLOGY AND PARASITOLOGY

The zoology laboratory will need to expand its work on tropical parasitic diseases after the war. Heretofore these diseases have been of little importance as public health problems in the continental United States. During slave-trading days, some of these diseases were introduced and at least one became established only to die out later. Since that time, however, there has been little opportunity for the importation of these diseases into the United States.

The present world conflict is rapidly changing this favorable situation. Unusually favorable facilities for disease dissemination are now being provided, and increased hazards have already resulted in this respect in this country. Many of our troops are in combat areas where tropical diseases are prevalent at all times, and many infected individuals will return to the United States. This is more likely in the case of the parasitic diseases than it is with diseases due to other etiological (i. e., causative) agents, because the former are characterized by a relatively long incubation period, pronounced chronicity, lack of permanent immunity, and difficulties in diagnosis. Furthermore, there are no available means of immunizing an individual against the parasitic diseases and for many of them no satisfactory treatment is known.

STUDY AND CONTROL OF DISEASE CARRIERS

Some tropical parasitic diseases have vectors or intermediate hosts in the countries where they normally occur. Inasmuch as our fauna contains near relatives of these vectors, it is necesasry to determine whether our domestic species can serve in the same capacity. Unless this determination is made, the public health significance of disease introduction into the United States cannot be evaluated. Expanded postwar air travel will continue to offer hazards. With cases of long-standing parasitic diseases in this country, the introduction and establishment of suitable vectors would be of tremendous public health significance. The expansion planned in the zoology laboratory is for the purpose of providing information needed for an appraisal of present and future hazards and for the application of control measures.

PARASITIC DISEASES NOW PRESENT IN UNITED STATES

Certain parasitic diseases are already endemic or normally present in this country. Surveys conducted by this laboratory indicate that the trichina parasite infects about 16 percent of our population, with the number of clinical cases an obscure question. *Endamoeba histolytica*, the cause of amoebic dysentery, has been found in 8 percent of over 110,000 persons surveyed. Hookworm disease is still endemic in most of our Southern States and remains an important public health problem in many areas. Evidence indicates that modern sewage treatment methods are deficient for the destruction of certain parasite ova and cysts in sewage; some of the practices in the disposal of sludge may be of importance in disseminating certain parasitic diseases.

Further studies on the immunology, pathogenicity, diagnosis, and treatment of parasitic diseases already present here are needed to provide information required for combating these diseases and raising public health standards.

Industrial Hygiene Research Laboratory

INDUSTRIAL HYGIENE RESEARCH

Industrial hygiene research is the study of (1) the effects of exposure to chemicals and to intermediate and finished products on experimental animals and the human organism, (2) the evaluation of physiological factors, such as posture and fatigue, on the efficiency of workers, and (3) the influence of environmental factors, such as noise, illumination, radiation, temperature, pressure, and humidity, on the health of workers.

NEED FOR SUCH STUDIES

Such studies are necessary for the protection of the health of workers, the prevention of occupational diseases, and the attainment of the greatest possible industrial efficiency since they are the foundation on which both medical and engineering control measures have to be based. The war has forcibly demonstrated that the application of the results of industrial hygiene research has increased the efficiency and health of the worker. The change from a war to a peace economy does not alter the need for industrial hygiene research.

KINDS OF INFORMATION OBTAINED

Investigations are conducted in the laboratory, in the field, and in hospitals. Information obtained by laboratory research is supplemented by study of the worker in his working environment and by clinical research in hospitals where treatment of workers suffering from occupational diseases is studied as well as the methodology of rehabilitation.

AIMS OF INDUSTRIAL HYGIENE RESEARCH

The aim of such investigations is not restricted to evaluation of the toxicological picture of such poisonings or of injuries resulting from other factors; they are directed also toward the development of methods for detecting incipient injury before more serious, and perhaps permanent, damage has been suffered by the workers. In addition, both laboratory and hospital facilities should be available for training personnel for scientific research and for control and treatment of hazardous conditions in industry.

ROLE OF THE FEDERAL GOVERNMENT

It should be the function of the Federal Government to develop fundamental information through research along the lines indicated. Findings would be made available to State governments and to industry for the purpose of controlling the working environment. In order to carry out the necessary research it is imperative that laboratory facilities and hospital facilities be available and that they be manned by highly trained personnel.

NEED FOR POSTWAR EXPANSION OF ACTIVITIES

Industrial hygiene research, because of the diversified nature of the problems with which it deals, demands the coordinated services of many scientific professions as well as adequate, often highly specialized, laboratory facilities. Research in industrial hygiene is of recent origin in the United States and has never been on a scale adequate to take care of all the great problems in the field. In addition, the use of new materials and new processes developed during the war will demand a considerable expansion and intensification of industrial hygiene research in the postwar period.

PROPOSED POSTWAR INDUSTRIAL HYGIENE PROGRAM

The following program, except for hospital research, calls for expansion of approximately three times the present activities of the Industrial Hygiene Research Laboratory. Expansion should be effected gradually so that by the conclusion of a 10-year period the program would be functioning completely. Present laboratory facilities at the National Institute of Health would need to be increased about 100 percent. Hospital facilities to house approximately 100 patients would be required, and these would be made available in the proposed 500-bed medical center hospital to be built at the institute.

A. Laboratory research

Postwar laboratory research in industrial hygiene should be developed along eight major lines:

1. *Industrial toxicology.*—Determination of the toxicity and potential dangers of solvents, plastics, synthetic rubbers and their components, metals, new alloys used in airplanes and motor vehicles, and of toxic dusts, gases, vapors, and fumes.

2. *Aviation medicine.*—The outstanding problems for postwar research in this field are expected to be:

(*a*) Selection of flight personnel.

(*b*) Determination of fitness for flight (personnel and passengers).

(*c*) The effects of pressure change in aviation on the human ear.

(*d*) Air sickness.

(*e*) Pilot fatigue.

(*f*) The human factor in airplane accidents.

(*g*) Research in collaboration with aeronautic engineers to overcome effects of lowered barometric pressure associated with lowered exygen pressure (pressurized cabin airplanes and oxygen supply equipment).

(*h*) Study of the effects of cold, noise, and vibration in collaboration with engineers.

(*i*) Effects of high acceleration and deceleration on passengers and crew in relation to the safety and comfort of high-speed air transport.

3. *Applied physiology.*—(*a*). Occupational research to ascertain optimum conditions for health and work of men and women. This would include, for example, an investigation of optimum hours for work, and optimum conditions for such environmental factors as temperature, humidity, barometric pressure, and lighting. A study of conditions to relieve occupational noise and occupational fatigue and the influence of such factors as nutrition on the health and productivity of the workers.

(*b*) Occupational research on the proper physical and psychological placement of the worker so that the maximum talent of each may be utilized. This would include special studies of older people and of physically handicapped workers, such as cardiacs and others convalescent from chronic diseases, for example, tuberculosis, so that they may be given jobs consistent with their capacity.

(*c*) Fundamental studies on the health aspects of postwar construction of buildings of all types. These include problems of lighting, interior color, air conditioning, sound proofing, and safety.

4. *Biophysics.*—(*a*) Development of physical methods, such as spectroscopic and electronic, for the detection of various compounds of importance in biology.

(*b*) Development of physical methods for the quantitative evaluation of such environmental factors as illumination, noise, radiation, and ventilation, and study of the biological effects of such factors.

(*c*) To determine the factors in molecular or atomic structure which are responsible for observed toxicities in man. An attempt to elucidate the mechanisms involved in the interaction of radiant energy and living tissues.

(*d*) The determination of normal responses of the eye to various physical conditions of lighting, glare, etc., and impairment to vision from improper conditions. The lowering of efficiency and increase in fatigue due to the performance of visual tasks under improper visual conditions.

(*e*) Extension of consulting service and laboratory facilities to other research units of the Public Health Service where services of a full-time physicist are not justified.

5. *Aerobiology.*—Studies on the control of air-borne bacteria and viruses by ultraviolet radiation, aerosols, filters, and electrostatic precipitation; the evaluation of the fundamental effect of radiation on bacteria, fungi, ova, and viruses, including genetic effect.

6. *Psychophysiology.* Development of techniques for the measurement of psychomotor efficiency under various environmental conditions. These techniques, which involve both motor and mental activities, are necessary in detecting incipient intoxication and reducing accident proneness thereby. In addition, the development of techniques for personality diagnoses is essential in improving the relationship of individuals who are working together and in groups. The fundamental scientific objective of the research will be oriented toward understanding the psychophysiological and neuro-physiological aspects of general efficiency of workers individually and in groups.

7. *Industrial pathology.*—(*a*) Histopathological investigation of animal material received from the above industrial hygiene groups.

(*b*) Development of clinical pathological methods applicable to industrial environmental exposure, such as special methods for detecting the early effects of lead on blood.

(*c*) Establishment of a register of human industrial pathological material received from clinical research hospitals for occupational diseases.

8. *Analytical chemistry.*—(*a*) Development of chemical methods of analysis with specific reference to the new compounds as they are introduced into industry.

(*b*) Modification of known methods of analysis for field use.

(*c*) Investigation of the chemical behavior of substances to be studied toxicologically, particularly new chemicals.

B. Field research

A necessary fulfillment of a research program affecting the health of workers is the study of the individual in his environment. This is an extension of the fundamental knowledge gained in laboratory research. In addition, clinical studies of workers in their environment may lead to new trends for further laboratory study. This field research would necessarily require the specialized personnel and facilities enumerated under "A", and would not require any new personnel or facilities.

C. Hospital research

This is primarily an extension of laboratory research on animals to man. The hospitalization of workers suffering from occupational diseases for intensive study and treatment with new therapeutic agents or procedures discovered in the laboratory. The medical appraisal, treatment, and rehabilitation of United States Employees' compensation cases. The following services will be required:

1. *Occupational diseases.*—Clinical study of workers suffering from industrial poisoning, with special reference to the study of organ function and treatment and clinical tests for the recognition of such poisoning.
2. *Occupational infections.*—Clinical study of workers suffering from occupational infections and parasitic infestations, such as cotton sickness, anthrax, brucellosis, and hookworm infestation.
3. *Occupational deformities.*—Clinical study of workers suffering from occupational deformities such as injuries of the peripheral nerves from use of pneumatic tools; deformities of the bones due to improper posture; injuries of the musculature due to overexertion. This would include the development of procedures for rehabilitation.
4. *Occupational injuries of female workers.*—Study of the effects of certain occupations on women, with special reference to the organs of reproduction.
5. *Occupational physiological stress.*—Study of fatigue, causes of accident proneness, and the relation of comfort of the worker to efficiency and health.
6. *Occupational age of the worker.*—Definition of types of employment suitable for young and old workers.

Other Scientific Research

BROAD SCOPE OF RESEARCH ACTIVITIES

The scientific work of the National Institute of Health covers an ever-widening range of laoboratory activities in specific fields, such as cancer and industrial hygiene, in the basic sciences, and in cooperative studies requiring group work. After the war. when chemical studies are undertaken in the new medical research hospital, there will be increasing demands on the several laboratoris in the institute.

THE CHEMISTRY LABORATORY

Chemical analyses are made in the chemistry laboratory to aid investigation of infectious diseases, dental caries, the processes of digestion, and other conditions. After the war the laboratory will expand to carry on studies of digestive enzymes. These chemical ferments are formed by living cells and accompany good health when they act normally; their improper functioning gives rise to digestive and metabolic disorders of the most deep-seated significance. More knowledge is needed of the ways in which these vitally important substances act. The promising lines for their study are now known to be in the chemical and biochemical fields.

THE PATHOLOGY LABORATORY

The evolution of disease processes in experimental animals is studied in the pathology laboratory where original investigations are initiated and where studies are conducted in cooperation with other divisions of the institute.

Additional work in the human pathology of the infectious diseases as well as their effects in experimental animals is needed, particularly in reference to those relatively less known infectious diseases occurring in tropical climates. At this time the pathology of the malarial fevers, the dysenteries, the leishmaniases (tropical parasitic diseases transmitted by species of sand flies), yellow fever, and the typhus-like fevers are of importance.

Further work is likewise needed on the relation of toxic substances and dietary deficiencies to such conditions as arteriosclerosis and cirrhosis of the liver.

BIOLOGIES CONTROL LABORATORY

This division of the institute is concerned with the legal control of the manufacture and sale of products used in the prevention and treatment of human diseases, such as serums, vaccines, viruses, and the like . Diphtheria antitoxin, vaccine virus, and antitetanus serum are a few of the products that have been tested and standardized by the Service. Years of research have been required for this work, but as a result the public has been protected from contaminated or subpotency products.

An expansion of postwar research will be needed in this work of controlling biologic products. Adequate methods of control are lacking in the case of some products present knowledge is insufficient. In developing new controls there must be preliminary study and trial and sometimes this requires years of work. Standards now in use should be reviewed; where necessary they should be improved and new standards should be developed

This laboratory for years has performed a most important public service. It will require increased personnel after the war to carry on its regular functions and to expand research activities. The Service issues licenses to some 50 manufacturing firms, covering over 150 different biologic products, every one of which must be subjected to periodic bacteriological or serological tests.

Bureau of Medical Services

1. Office of Chief of Bureau:
    (*a*) Emergency Medical Section
    (*b*) Office of Nursing
2. Hospital Division:
    (*a*) Marine hospitals and medical relief stations
    (*b*) Sheepshead Bay Hospital
    (*c*) Freedmen's Hospital
3. Mental Hygiene Division:
    (*a*) Lexington Hospital
    (*b*) Fort Worth Hospital
    (*c*) Mental hygiene studies
4. Foreign Quarantine Division:
    (*a*) Maritime quarantine
    (*b*) Aircraft quarantine
    (*c*) Immigration
5. Medical care services for other governmental agencies:
    (*a*) War Shipping Administration
    (*b*) Office of Indian Affairs
    (*c*) Bureau of Prisons
    (*d*) United States Employees Compensation Commission
    (*e*) Coast Guard
    (*f*) Farm Security Administration
    (*g*) Office of Vocational Rehabilitation
    (*h*) Medical Division, Office of Civilian Defense
    (*i*) Detention centers
    (*j*) Public Roads Administration

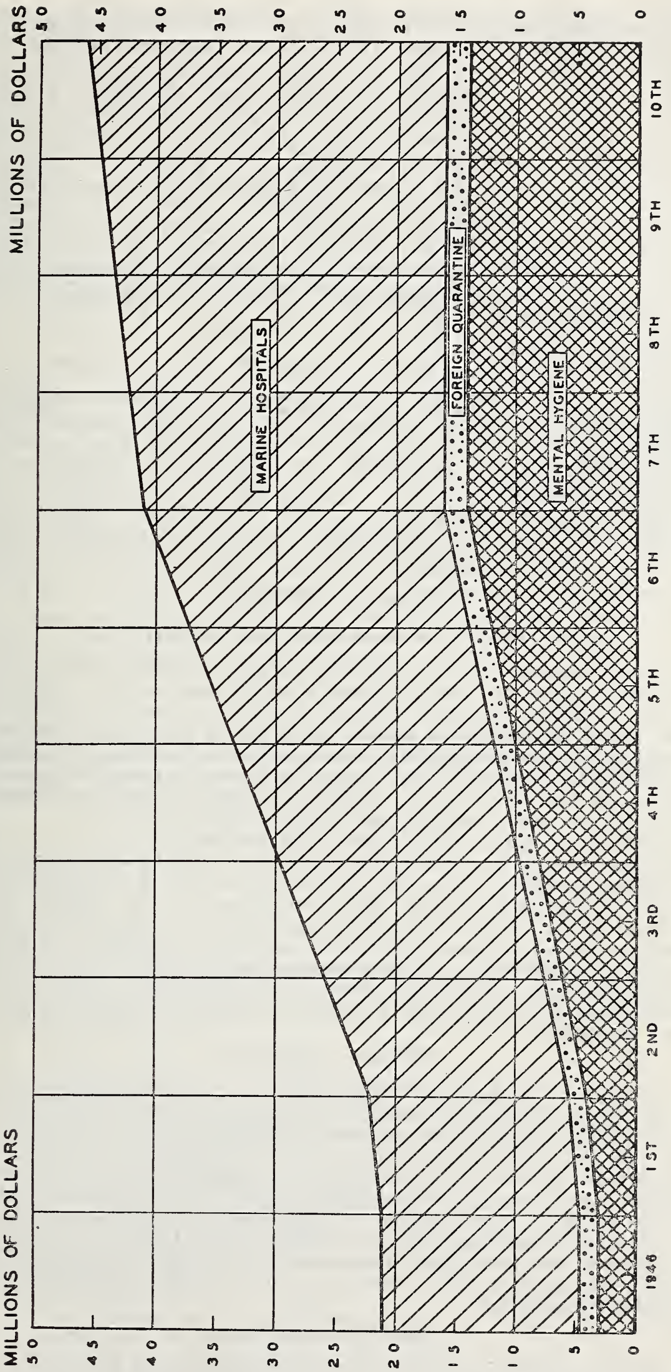

MILLIONS OF DOLLARS
MILLIONS OF DOLLARS
50
45
40
35
30
25
20
15
10
5
0
1946
1ST
2ND
3RD
4TH
5TH
6TH
7TH
8TH
9TH
10TH
MARINE HOSPITALS
FOREIGN QUARANTINE
MENTAL HYGIENE

Exhibit J.—*Postwar budget and personnel requirements of the Bureau of Medical Services, fiscal year 1946, and first, sixth, and tenth postwar fiscal years*

Division	Fiscal year ending June 30, 1946		First postwar fiscal year		Sixth postwar fiscal year		Tenth postwar fiscal year	
	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget
Total budget		$20, 778, 896		$22, 115, 130		$40, 683, 150		$46, 397, 150
Total operating expenses		20, 778, 896		21, 115. 130		30, 466, 150		36, 180, 150
Total grants-in-aid for services				850, 000		8, 717, 000		8, 717, 000
Total grants-in-aid for demonstrations and training				150, 000		1, 500, 000		1, 500, 000
Total personnel	7, 071		7, 105		9, 901		12, 159	
Hospital Division	5, 689		5, 689		7, 923		10, 156	
Operating expenses		16, 674, 380		16, 674, 380		24, 789, 000		30, 373, 000
Mental Hygiene Division	725		745		1, 250		1, 275	
Operating expenses		2, 615, 000		2, 735, 000		3, 710, 000		3, 840, 000
Grants to States for services				850, 000		8, 717, 000		8, 717, 000
Grants for demonstrations and training				150, 000		1, 500, 000		1, 500, 000
Foreign Quarantine Division	657		671		728		728	
Operating expenses		1, 489, 516		1, 705, 750		1, 967, 150		1, 967, 150

Marine Hospitals

PLACE OF MARINE HOSPITALS IN USPHS

The Marine Hospital Service is one of the oldest functions of the Federal Government, dating back to 1798. Originally established to give medical relief to seamen of the merchant marine, this service for many years consisted of a few hospitals administered from a central office in the Treasury Department. As public health services developed in this country and additional authority was given to the Marine Hospital Service by Congress, the original name lost its appropriateness and was changed in 1902 to "Public Health and Marine Service." In 1912 the name was shortened to Public Health Service.

The Marine Hospital Service is now a part of the Hospital Division, Bureau of Medical Services, of the Public Health Services. It operates through 26 hospitals, including the national leprosarium at Carville, La., and Freedmen's Hospital in the District of Columbia. These hospitals furnish medical services to Aemrican merchant seamen, Coast Guard personnel and their dependents, Coast and Geodetic Survey personnel and their dependents. Federal beneficiaries of the Employees' Compensation Commission, officers and employees of the Public Health Services, and other legally designated beneficiaries. Over 1,000,000 patients were treated in the marine hospitals in 1943 and nearly 2,500,000 days of care were furnished.

RESEARCH ACTIVITIES

Staff members of the marine hospitals have made many valuable contributions leading to improvements in clinical techniques. Continuous caudal analgesia in obstetrics was developed by two members of the staff at the Staten Island marine hospital. By this method trained physicians were able to accomplish safe and painless childbirth in about 90 percent of hospitalized deliveries. This method of analgesia has been found to be applicable to other fields of medicine and surgery, and its use has been demonstrated to many civilian practitioners and hospital staffs. At the United States Marine Hospital, Ellis Island, N. Y., a neuropsychiatric service was developed. Organized and staffed by competent psychiatrists and neurologists, it has proved invaluable to patients suffering from mental and neurologic conditions.

POSTWAR EXPANSION

The marine hospitals are badly crowded and many need repairs and improvements. It is recommended that 5 new hospitals be built and that replacement or extension of existing facilities be undertaken at 21 marine hospitals and at Freedmen's Hospital. Quarantine stations at San Diego and San Francisco, Calif., Galveston, Tex., and Honolulu, T. H., should be replaced, and the stations at Baltimore, Md., and Tampa, Fla., should be replaced or the existing facilities should be extended.

This construction program will cost approximately $61,000,000, and it might appropriately be extended over a 5-year period. The additional facilities are urgently needed, for the number of statutory beneficiaries has greatly increased and postwar needs for services are expected to rise. The situation in Philadelphia may be cited as an illustration. The nearest marine hospitals to this city are located in Baltimore, Md., and Ellis Island, N. Y. Four separate hospitals in Philadelphia are now under contract with the Government for the furnishing of in-patient care to Service beneficiaries. Patients from this area requiring long-time care must be shipped to the nearest marine hospital. This situation could be corrected if a 400-bed marine hospital were erected in Philadelphia to care for the Service beneficiaries of this important commercial and maritime center. (Detailed estimates for each project have been prepared.)

Foreign Quarantine

CURRENT ACTIVITIES

The Division of Foreign and Insular Quarantine and Immigration engages in numerous activities in all parts of the world. It inspects new vessels for foreign trade to assure their sanitary and ratproof construction; it clears vessels from foreign ports and fumigates them when necessary; through quarantine stations at seaports and, more recently, at airports, it protects this country from the invasion of epidemic diseases from other parts of the world. Working with the Government of Mexico, this Division examines agricultural laborers before they leave their native towns so as to avoid rejections at the border. Similarly, medical officers of the Public Health Service are detailed to Jamaica and other islands to examine laborers imported therefrom. Finally, all applicants for immigration visas are medically examined and certified by the medical officers of the Division. During the war this last function has been confined to Cuba, Canada, Great Britain, and the Irish Free State.

POSTWAR ACTIVITIES

When hostilities end the activities of the Division will expand as a result of the opening of quarantine activities in Europe, China, and Honolulu. There will be a budget increase of about 10 percent during the first five postwar years, and thereafter expenditures will level off.

Bureau of State Services

1. Office of Chief of Bureau:
    - (*a*) Allotments
    - (*b*) Audits
    - (*c*) Merit system
    - (*d*) Liaison officers
    - (*e*) Office of Public Health Nursing
2. States Relations Division:
    - (*a*) Interstate quarantine
    - (*b*) Plague control
    - (*c*) Malaria control, war areas
    - (*d*) Typhus control
    - (*e*) Emergency health and sanitation
    - (*f*) Lanham Act activities
    - (*g*) Public health dentistry
3. Venereal Disease Division:
    - (*a*) Control methods and procedures
    - (*b*) Consultation service to States
    - (*c*) Hot Springs Training Center
    - (*d*) Rapid treatment centers
4. Industrial Hygiene Division:
    - (*a*) Field operations
    - (*b*) Consultation service to States
    - (*c*) Inspection teams, Government plants
5. Tuberculosis Control Division:
    - (*a*) Office of the Chief
    - (*b*) State Aid Control Section
    - (*c*) Radiology Section
    - (*d*) Field Studies Section

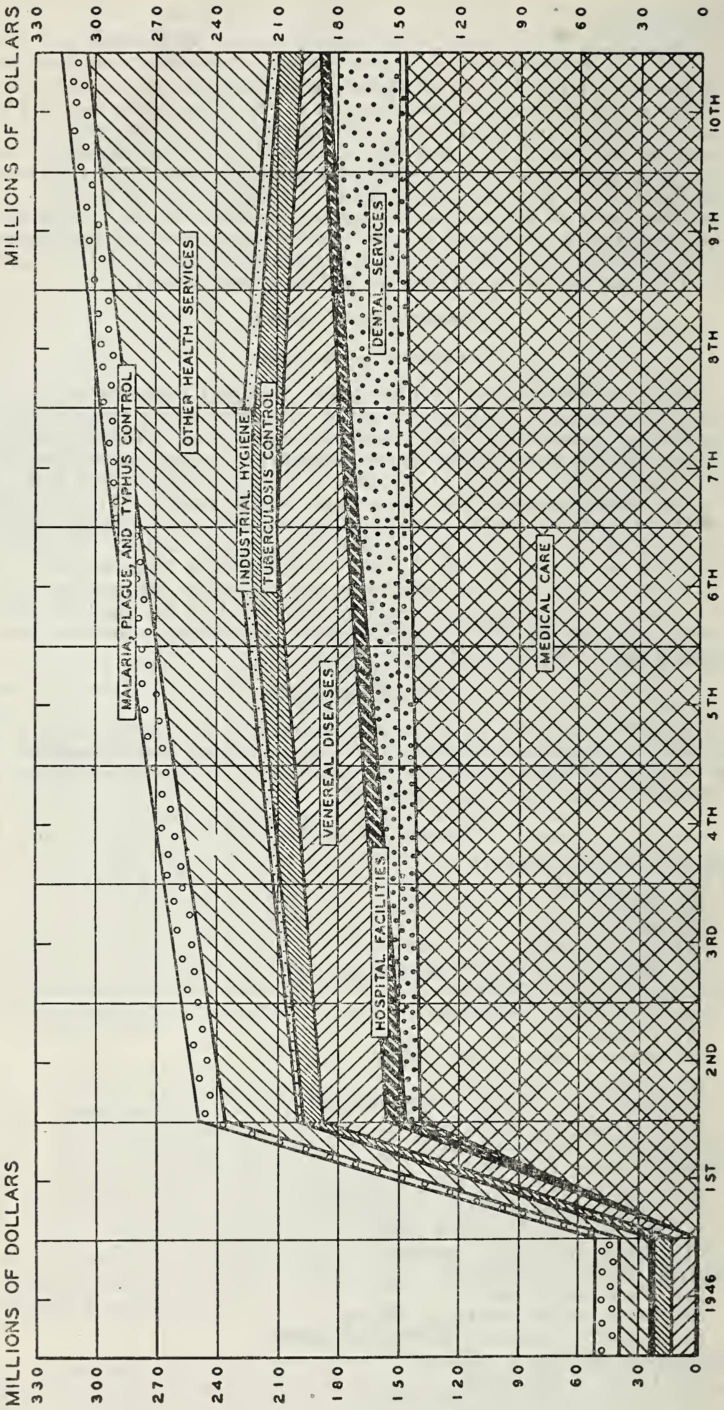

MILLIONS OF DOLLARS
330
300
270
240
210
180
150
120
90
60
30
0
1946
1ST
2ND
3RD
4TH
5TH
6TH
7TH
8TH
9TH
10TH
MALARIA, PLAGUE, AND TYPHUS CONTROL
OTHER HEALTH SERVICES
INDUSTRIAL HYGIENE
TUBERCULOSIS CONTROL
VENEREAL DISEASES
HOSPITAL FACILITIES
DENTAL SERVICES
MEDICAL CARE

EXHIBIT K.—*Postwar budget and personnel requirements of the Bureau of State Services, fiscal year 1946, and first, sixth, and tenth postwar fiscal years*

Division	Fiscal year ending June 30, 1946, current activities		First postwar fiscal year		Sixth postwar fiscal year		Tenth postwar fiscal year	
	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget	Number of persons	Budget
Total budget		$50,778,493		$257,558,412		$291,103,519		$317,257,035
Total operating expenses		21,470,148		37,633,412		46,759,644		38,873,160
Total grants-in-aid		29,308,345		219,343,875		244,343,875		278,383,875
Total personnel	8,199		9,074		11,513		13,095	
States Relations Division:								
Office of Public Health Nursing	99		120		(1)	(1)	(1)	(1)
Operating expenses		266,115		335,255	(1)	(1)	(1)	(1)
Grants for training				4,000,000	(1)	(1)	(1)	(1)
Grants to States for services				4,021,700	(1)	(1)	(1)	(1)
Dental services to States	34		121		121		121	
Operating expenses		161,836		541,200		541,200		541,200
Grants to States for services				7,000,000		25,000,000		37,000,000
Grants to States for research				75,000		450,000		450,000
Assistance to States—general	255		590		2,746		4,711	
Operating expenses		1,212,198		2,308,785		10,260,465		16,480,435
Grants to States for general health program		11,000,000		33,219,955		33,920,663		70,625,430
Assistance to States—special war program	350							
Operating expenses		1,132,912						
Control of communicable diseases	204		247		219		204	
Operating expenses		478,066		774,614		733,497		768,066
Malaria control	5,339		5,339		5,339		5,339	
Operating expenses		12,247,565		12,247,565		12,247,565		12,247,565
Milk and food sanitation—special war program	44							
Operating expenses		166,862						
General health and sanitation services for foreign and domestic military zones			320		320		320	
Operating expenses		853,000		853,000		853,000		853,000
Field laboratories:								
San Francisco			40		70		70	
Operating expenses				300,000		500,000		500,000
Memphis			40		70		70	
Operating expenses				300,000		500,000		500,000
Hospital Facilities Section	22		103		124		103	
Operating expenses		78,160		425,760		512,650		425,760
Grants to States for surveys				5,000,000				
Grants to States for administering hospital construction program				4,700,000		5,860,000		4,100,000
Venereal Diseases Division	1,128		1,225		1,225		1,075	
Administration		20,560		20,560		145,560		20,000
Other operating expenses (including demonstrations and cooperative studies)		2,481,879		3,431,879		2,625,858		2,128,430
Rapid-treatment centers		356,145		12,731,145		12,731,145		
Grants to States		9,827,800		16,427,800		19,862,337		8,057,570
Industrial Hygiene Division	135		200		355		355	
Operating expenses		559,994		1,055,793		2,122,653		2,122,653
Grants to States and universities						2,950,875		2,950,875
TB control	409		409		600		400	
Operating expenses		1,821,805		1,821,805		2,500,000		1,800,000
Grants to States		8,480,545		8,480,545		12,500,000		8,200,000

---

[1] Transferred to the Office of the Surgeon General.

General Assistance to States for Health Services

CURRENT ASSISTANCE TO STATES

Under title VI at the present time $11,000,000 are available annually for Federal grants-in-aid to States for a wide range of health services. In 1943 the Public Health Service contributed through these grants not quite $1 in every $10 spent by State and local governments for cooperative health work. Title VI funds were used by States for the training of health personnel, administration, control of preventable diseases, laboratory services, vital and other statistical studies, evironmental sanitation, supervision of local health services, public-health education, the promotion of industrial hygiene divisions in State health departments, and numerous other activities.

PROPOSED POSTWAR EXPANSION

It is proposed that grants-in-aid be expanded either by increasing the title VI funds or by making earmarked funds available or by both methods. A tenfold increase would be desirable over the 10-year period after the war. The major items would be, roughly: $140,000,000 annually ($1 per capita) to implement a national medical-care program; $37,000,000, in the tenth year, for dental services; and some $70,000,000, in the tenth year, for various services now dependent on title VI funds and others not specifically provided for elsewhere, as, for instance, those for patients suffering from cancer and other chronic diseases.

Expenditures for tuberculosis are expected to decline as are those connected with the hospital-construction program and control of venereal diseases. Industrial-hygiene services will be stabilized at about $5,000,000 a year, including $2,000,000 for operations and $3,000,000 for grants. Malaria, plague, and typhus-control programs will tend to stabilize after ditching and drainage work and rodent proofing have been reduced to a current-operations job.

FEDERAL EXPENDITURE

The cost of these services which are designed to raise the health level of the entire population would amount to a Federal expenditure of about $2 per capita in the tenth postwar year. This is a small outlay for the benefits that will be conferred.

Mental Hygiene

MAGNITUDE OF MENTAL HYGIENE PROBLEM

When one surveys the Nation's postwar needs in the field of medicine, the incidence of neuropsychiatric disorders and the lack of facilities and personnel for properly treating them stand out sharply. A poll of both professional and lay opinion would place the need for an organized attack upon this problem high on the list of endeavors which must be undertaken. Any condition which filled over half of all the hospital beds in the country before the war, and which certainly has not decreased in incidence since the onset of hostilities, must be dealt with as one of the Nation's greatest medical needs. The problem of the adjustment of the members of our armed forces as they return to civilian life, and of their families, is one which must be met expertly.

ADMISSION TO MENTAL HOSPITALS IN 1940

In 1940, 163,556 patients were admitted to hospitals for mental diseases and defects—only 10,000 fewer than the number of persons who graduated from college that year. In addition to the individuals who were admitted to institutions, there was an unknown number who continued to live in society in a more or less handicapped condition—ineffective as members of a social order in which all must contribute to the common good. The 163,556 represent only those who could not continue the struggle at all and who consequently went down in defeat.

COMPLEXITY OF PROBLEM

The problem of the neuropsychiatric disorders is a complex one involving (1) study of the cause or causes of the disorders, (2) development of new methods of bringing the therapeutic procedures now at our disposal to those needing assistance, and (3) research in the epidemiology of the disorders. All three aspects of the problem must receive attention if intelligent treatment is to be instituted.

PROPOSED POSTWAR PROGRAM

In order to meet the needs as now known and to encompass all phases of the problems of mental health, a program must be so designed as to be flexible enough to meet the exigencies as they may arise and yet adhere to the primary objective of preventing and treating neuropsychiatric disorders. The program naturally follows four closely integrated lines of endeavor: (1) Out-patient care in clinics; (2) in-patient care in clinics; (3) training of personnel and dissemination of information; (4) research directed to throw light upon the etiology, nature, and spread of neuropsychiatric disorders, and on improved methods of treatment.

Each of the four lines of endeavor is dependent upon the other three if it is to serve its greatest usefulness, and until all four are in proper operation the attack upon the problem cannot move forward on all fronts. An outline of the component activities of this program follows; mental-hygiene-research activities, when undertaken. will be in the National Institute of Health.

OUT-PATIENT CLINICS

A. Types:
  1. Prophylactic:
    (*a*) School clinics.
    (*b*) Mental health units in colleges and universities.
    (*c*) Marriage and other counseling clinics.
    (*d*) Clinics connected with the courts and probation offices.
    (*e*) Child guidance clinics.
    (*f*) Adult psychiatric clinics.
  2. Follow-up clinics:
    (*a*) Stationary and traveling clinics functioning as adjuncts to mental and other hospitals for the purpose of following and assisting paroled and discharged patients.

B. Functions:
  1. Clinical.
  2. Training of personnel.
  3. Collection of statistical data.
  4. Dissemination of information.

C. Administrative:
  1. Work through such stable, responsible, public and private organizations as are available, such as the health department, department of mental hygiene, etc.
  2. Headquarters advisory group.
  3. Loan of personnel from Public Health Service when requested for development of local program.
  4. Aid to medical schools for purpose of establishing adquate training facilities.
  5. Aid to States and localities for training of personnel.

HOSPITALS

A. Public Health Service:
  1. Establishment of neuropsychiatric service on staff in all of the major hospitals, at least.
  2. Establishment of a high type of training center at one or more of the Public Health Service hospitals.

B. State and other psychiatric hospitals:
  1. Further development of inspection and advisory service now in existence.
  2. Grants-in-aid for training of personnel.
  3. Assistance in establishment of high-class psychiatric hospitals in connection with medical schools.
  4. Encouragement to provide economic assistance to dependent families of the psychiatrically disabled.
  5. Encouragement of research in State hospitals by grants-in-aid and fellowships.
  6. Tangible encouragement to improve physical plants and equipment.
    (*a*) Assignment of a psychiatric hospital architect to headquarters.
  7. Loan of personnel for establishment of approved, modern psychiatric hospital methods and procedures.

TRAINING AND DISSEMINATION OF INFORMATION

A. Training and dissemination of information:
    1. Physicians, psychologists, social workers, nurses, rehabilitation aides, and other personnel.
        (*a*) Training of service personnel to be loaned to States.
        (*b*) Grants-in-aid to State for training purposes.
B. Demonstrations:
    1. Development of mobile teams, carefully selected for teaching ability, to demonstrate and teach therapy and care when requested.
C. Dissemination of information:
    1. Pamphlets and other publications.
    2. Preparation and circulation of movies.
        (*a*) For professional people.
        (*b*) For nonprofessional people.
    3. Preparation of study courses, material for discussion groups, etc.
    4. Lectures.

RESEARCH

A. Development of a research center to investigate all phases of the problem of neropsychiatric disorders:
    1. Erection of a hospital and laboratory as one physical unit.
    2. Legislation to permit the appointment of personnel, including fellows, of the highest type, without regard to civil-service restrictions.
    3. Gathering of statistical data on a Nation-wide basis.
    4. Assembling of a national psychiatric library.
    5. Granting of research fellowships at service center and elsewhere.
    6. Grants-in-aid to other institutions for research.

CONTROL PROGRAMS, MALARIA, PLAGUE, AND TYPHUS

MALARIA-CONTROL ACTIVITIES

The present Office of Malaria Control in War Areas employs over 5,000 workers—engineers, entomoligsts, inspectors, laborers, etc.—and spends about $10,000,000 a year to carry on its activities. This work should be continued after the war on at least as large a scale as at present. Activities are of three types:

1. Removal of existing hazards of malaria transmission;
2. Experimentation with new methods; and
3. Prevention of the creation of new breeding places of the malaria-carrying mosquitoes. (In the United States one species of mosquito, *Anopheles quadrimaculatus*, transmits practically all the malaria.)

HAZARDS OF MALARIA TRANSMISSION

Epidemiological studies indicate that the hazards of malaria transmission in the United States at this time are of three kinds:

7. Endemic foci of infection where malaria transmission is active.
2. Areas where malaria transmission has been active within recent years, but where transmission appears to be inactive at the present time.
3. Areas where malaria has not been actively transmitted for a long time, but where the carrying, or vector, mosquito is present in considerable number.

STEPS IN POSTWAR PROGRAM

The first malaria-control work should be done in those areas where malaria is now present. These foci comprise portions of 68 counties of the Southeast. During the progress of this work the hazardous areas of the second category (recently malarious) would be delineated. It is probable that work commencement in the second category would absorb expenditures at the approximate rate of discontinuance in the first. It is estimated that these two types of control activities will last from 3 to 5 years.

The third line of attack should be in areas which are now free of malaria but high in density of Anopheles mosquitoes. These areas will define themselves by small outbreaks wherever the hazard of malaria transmission is great enough, soon after the introduction of the increased carrier population from troops returned from tropical duty. A number of small mobile control crews should be effective in handling the temporary situations so created.

EDUCATIONAL PROGRAM NEEDED

This is an age of impounded waters where anopheline control is difficult. An intensive educational program is essential to prevent the growing indiscriminate creation of serious large breeding places. This educational program should be integrated with the conservation and agricultural programs designed to conserve the ground water. Soil erosion and a falling water table cause silting and pooling of streams which is increasingly changing harmless flowing streams into larger and larger breeding places of *Anopheles quadrimaculatus.*

It is desirable to experiment with the new method of malaria control of internal house spraying with a long-lasting insecticide. The method is successful where efficiently performed. Whether a wholesale demonstration will result in its voluntary use by the bulk of the people remains to be seen.

LENGTH OF PROGRAM

The program here outlined would probably operate at the maximum for approximately 5 years, and then rapidly reduce to one or two million for 1 or 2 years, and then further reduce to a minimum inspection and educational program. The terminal continuing program would hardly cost not more than $250,000 a year.

PLAGUE, A DISEASE OF RODENTS

Plague is another of the great epidemic diseases that is primarily a disease of rodents, human cases as a rule depending upon the existence of epizootics among rats. Our principal protection against the disease, therefore, is control of rats which is in every way similar to control of rats to prevent typhus fever. The same rat fleas that carry typhus are the principal vectors, or intermediate hosts, of plague, both among rats and from rats to human beings.

While human outbreaks are usually in relation to rat epizootics, the great reservoir of plague in the United States is in other rodents, principally ground squirrels, chipmunks, and similar burrowing and colonizing rodents.

EXTENT OF PLAGUE INFECTION IN UNITED STATES

Plague is present in field rodents in the Western States in an area comprising about one-third the country. It is spread over the States of Washington, Oregon, California, Nevada, Idaho, Utah, Arizona, Wyoming, Colorado, New Mexico, and North Dakota. As long as the disease in these States is confined to rodents other than rats, very few human cases occur. At times, however, the infection passes from the fields to urban areas where rats abound, whereupon more or less severe outbreaks of human cases result. So far the west coast cities of Los Angeles, San Francisco, Oakland (and adjoining communities), Portland, Tacoma, and Seattle have been infected at one time or another. Other cities, however, in the infected areas are menaced and their rat populations may become infected. The disease has been creeping eastward in recent years, and will threaten more populous areas as it progresses. In time we may expect that the large cities of the Mississippi Valley will develop outbreaks of plague.

PROPOSED SUPPRESSIVE MEASURES

To protect urban communities of the Middle West and East against the threat of plague, it is proposed to carry out in the States west of the Mississippi River plague-suppressive measures along the same lines as are projected for typhus-control measures in the Southern States.

PLAGUE ERADICATION NOT FEASIBLE

Eradication of plague infection in this country is not believed, under present conditions, economically feasible. It is spread over a tremendous area and would involve virtual extinction of several species of rodents. The cost of such an undertaking would certainly run into hundreds of millions. On the other hand, plague prevention in the urban communities west of the Mississippi is regarded as entirely feasible and could probably be accomplished at a cost comparable to that of typhus control in the South.

NEED FOR TYPHUS CONTROL

In the United States typhus fever is almost exclusively of the murine type. Primarily, this type is a disease of rats with human cases secondary to epizootics. The principal vectors between rats, and between rats and man, are rat fleas. Human cases are not a factor in the spread of the disease. In consequence, principal efforts are directed against the disease as it occurs in rats, and, for practical purposes, are directed toward the eradication of rats, their elimination from human habitation, and the destruction of rat fleas.

CONTROL PROCEDURES

The presently most successful procedures are to close all openings in the peripheries of buildings through which rats can gain entrance, then to destroy rats remaining in these buildings. Thereafter periodic inspection is required with maintenance of ratproofing and further rat destruction as indicated. By these means the rat population is reduced and largely separated from the human population. In addition, general measures are taken to destroy rats and rat fleas. These comprise trapping, poisoning, spraying of premises with insecticides, and, as an important adjunct, the control of garbage and its proper disposition so it will not serve as rat food.

The control of typhus and other rat-borne diseases is a continuing program and requires the establishment of trained personnel in local, State, and Federal health agencies. In particular is it necessary to train inspectors to recognize the signs of rats and to estimate their numbers. Ratproofing experts likewise must be trained to advise as to proper methods and to supervise installation.

An essential for control of typhus is adequate community legislation, for which the Public Health Service has already prepared model ordinances.

FIVE-YEAR DEMONSTRATION PROPOSED

It is proposed to carry out a 5-year demonstration throughout the area where typhus fever is prevalent or likely to spread. It is believed that this demonstration will to a material degree bring the disease under control within that period and that it will result in the establishment of a continuing typhus-control program in the great majority of States, counties, and communities throughout that area.

TYPHUS-INFECTED AREAS

The principal typhus-infected areas of the country today comprise the States of North Carolina, South Carolina, Georgia, Florida, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas. It is probable that the disease may spread in material amount into part or all of the States of Maryland, Virginia, West Virginia, Kentucky, Missouri, Kansas, and Colorado. At present writing, it seems unlikely that typhus will become a serious menace in other areas in the United States.

TYPHUS CONTROL METHODS AND COSTS

Methods for the control of the rat-borne diseases have been greatly improved in recent years and are not nearly so costly as heretofore. Furthermore, they are still in process of active development so that administration and procedures are constantly being changed and improved. In consequence, it is not possible to present at the moment an itemized budget sheet. In view of experience to date, however, in carrying out a limited typhus-control program in the Southern States, it would appear that a 5-year program would require about 77 million man-hours at a cost of something over $43,000,000 and about $23,000,000 worth of materials, equipment, and maintenance.

Hospital Facilities

BASIC ELEMENTS OF A SOUND HOSPITAL PROGRAM

After the war, we may expect a reorganization of health and medical services for the purpose of facilitating their better distribution. The hospital will be the key to the situation. The way must be found to assure three things in connection with hospitalization: (1) Availability and accessibility of physical facilities to the entire population; (2) the maintenance of professional standards; and (3) financial maintenance of facilities.

CONSTRUCTION PROGRAM

If the construction program here proposed is carried out during the first postwar decade there should be adequate hospital facilities for the entire population. Each State will be encouraged to survey its needs and to prepare a master plan as a guide to future hospital construction. Care should be taken to have the right kind of hospital in the right place and to determine in advance that each hospital erected shall be consistent with the over-all plan. Service areas should be considered; the position and size of present facilities should be plotted; estimated needs, based on accepted criteria, should be set down. Preliminary, overall estimates have been made already; the details must be filled in by States and localities.

Approximately 417,000 beds, including 238,000 new and 179,000 replacement beds, are needed for general, tuberculosis, and mental hospitals. To these must be added 2,400 health centers to house community health services, and an indeterminate number of hospitals for persons suffering from chronic diseases. The entire program will cost about 2.3 billion dollars, including funds from all sources. If it be assumed that there will be a slight lag in getting started and that the construction peak will be reached in the third postwar year, it is possible that 60 percent of the program will be completed during the first five postwar years. There is a possibility that here, as in other construction programs, there will be a decline of activity after the first rush and that the second 5-year period may be marked by smaller expenditures, lessened construction activity, and a decline in employment.

MAINTENANCE OF PROFESSIONAL STANDARDS

In determining service areas it is important to make sure that there shall be certain hospitals of sufficient size and quality to be deemed primary or teaching centers. Ordinarily there will be an existing hospital that could be approved for the teaching of nurses, technicians, interns, and resident physicians. Each of the primary teaching centers should, where possible, be associated with a university medical school as the nerve center of the hospital network within the State. The primary teaching centers in each State should in turn be associated with all the other hospitals of lesser magnitude within their sphere of influence. The pattern of this plan has been set by a philanthropic activity in Boston known as Bingham Associates. This plan operates primarily in Maine and is largely rural in character. It has proved to be very effective in raising the quality of rural hospital care.

FINANCIAL MAINTENANCE OF FACILITIES

There are several ways in which financial maintenance of facilities may be assured after hospitals are built. In economically depressed areas there may be heavy reliance on Federal grants-in-aid to pay for all or part of the hospital services rendered. Private funds may be used in certain areas, as in the case in North and South Carolina where the Duke Endowment pays to all approved general hospitals $1 per day for each day of free hospital care given. Blue Cross plans will undoubtedly help certain groups in the population to meet the costs of hospitalization, thereby lightening the financial burden of hospitals. It is also to be borne in mind that if the United States succeeds in maintaining a high level of employment and in stabilizing national income at $160,000,000,000, the majority of the population will be able to pay for hospitalization and the problem of financial maintenance will not be as serious as in prewar periods of depression, low national income, and mass unemployment.

CONTROL OF VENEREAL DISEASES

PRESENT CONTROL RATE INADEQUATE

Nearly 200,000 persons each year who are infected with syphilis either do not seek treatment or delay coming to treatment until the disease has passed the early stages during which the spread of the infection occurs. The extent to which the case-finding program can be intensified and persons placed under a schedule of therapy which can be completed before the infected person is lost to treatment will determine the duration of the fight against syphilis.

MAGNITUDE OF CURRENT SYPHILIS PROBLEM

There are at present under treatment 489,000 persons infected with syphilis. Each year 406,000 persons are newly infected. Of these, 326,000 reach treatment sources, but 80,000 fail to seek treatment. Of those who had reported for treatment prior to 1944, 163,000 failed to complete the treatment. Of those seeking treatment, 210,000 are treated in the first year of the disease. Only 51 percent of the problem, therefore, is being met.

CASE FINDING, DEMONSTRATIONS, AND ACTION PROGRAMS

The treatment facilities that are required are being adequately provided for with funds made available under the Lanham Act. Public Health Service funds, through 3,800 clinics, provide sufficient diagnostic facilities. The primary need is for additional personnel. These must be recruited and trained in case finding techniques if the job is to be completed. It is estimated that $10,000,000 will be required for (1) augmenting case finding, with the aid of demonstrations; (2) training programs, to provide qualified personnel; and (3) action programs.

It is proposed that with these funds one follow-up worker with transportation be employed for each of the 3,800 clinics. This worker is to be in addition to the present staff and is to be paid at the rate of $2,000 per annum.

POSTWAR POSSIBILITIES FOR CONTROL OF SYPHILIS

The close of the war would permit the immediate recruitment of workers trained in venereal disease control in the armed services which would cut the time of training and permit use of the previous training in venereal disease control.

With such an augmentation, it is prognosticated that syphilis could be brought under control within 5 years and the total appropriation of venereal disease control be curtailed to 3.5 million dollars. These funds will be required to maintain a preventive control unit within each local health department on a continuing basis.

POSTWAR BUDGET

During the first five postwar years it is estimated that annual appropriations of 33.5 million dollars will be required to carry out this program. Beginning in the first postwar year there should be available 12.5 million dollars for training and demonstrations; $10 million dollars for case finding; and 11 million dollars for maintenance and operation of rapid treatment centers. At the end of the 5 years, the budget should drop to 3.5 million dollars for maintenance of a preventive control program.

GONORRHEA CONTROL

At the present time there are under treatment 316,000 persons infected with gonorrhea. The average monthly patient load in clinics is 34,000 persons. Present-day therapy suggests the possibility of a one-injection treatment for gonorrhea. Diagnostic and treatment facilities are adequate to give this one-injection treatment. The proposed augmentation of the case-finding measures for syphilis also would serve to bring in the gonorrhea. Since the penicillin treatment for syphilis is equally effective for a coexisting gonorrhea, there will be in some patients a simultaneous cure.

Therefore, the funds requested for the control of syphilis also will provide the funds needed for gonorrhea control.

Industrial Hygiene, State Services

HEALTH CONSERVATION OF WAR MANPOWER

The Nation-wide industrial hygiene program in effect today has for its objective the health conservation of our manpower. Estimates based on the 1943 labor force of 57,000,000 workers show that more than 500,000,000 man-days were lost annually from all types of disability, while the economic cost amounted to approximately $10,000,000,000. As of August 1944, the civilian labor force has decreased to approximately 53,000,000 workers but due to increased employment of women, the aged, and the physically handicapped, and changes in the type of production, the industrial health problem has been intensified. Problems which have been precipitated by the war effort result from (1) the working environment, (2) the community environment, and (3) the varying health requirements of the new labor force.

An organization of approximately 500 persons in the United States Public Health Service and in 38 industrial States, where about 95 percent of the country's labor force is employed, is now actively serving industry within obvious limitations imposed by meager funds and staffs. Due to these limitations it has been possible to furnish only a small part of the necessary services.

EFFECT OF TERMINATION OF HOSTILITIES

Cessation of war activities will not reduce the need for industrial hygiene services. The transition from war to normal production will create the necessity for changes in materials and processes used, and in the types of jobs. The millions of workers now on war work will need to be taught new trades and tasks, and the millions of mobilized men will need physical as well as vocational rehabilitation. The transmigration of workers will be acute and more drastic than today; this will create further social and economic dislocations in our working population and augment the problems of medical care.

POSTWAR INDUSTRIAL HYGIENE NEEDS

Postwar industrial hygiene needs, and the plans to meet these needs, can be considered under the following three categories:

I. Direct services to Federal, State, and local governmental agencies, industry, labor, and other interested groups.

II. Postgraduate training of scientific personnel through grants-in-aid to selected universities.

III. Grants-in-aid to State and local governmental agencies furnishing industrial health services.

To accomplish these services a total annual appropriation of $5,000,000 for industrial hygiene investigations will be necessary. It is assumed that this amount will be required in the third year after the war. Appropriations for the first and second years should be $3.000,000 and $4,000,000, respectively. During these 2 years approximately $750.000 per year should be made available as grants-in-aid to universities, and approximately $400,000 per year should be spent on the construction of new buildings for the Industrial Hygiene Division.

I. DIRECT SERVICES

Continuation of the present work of the Industrial Hygiene Division in coordinating industrial hygiene work on a Nation-wide basis will require an annual expenditure of $2,066,860 for direct services to the States. These services will be handled by six units under the direction of the Chief of the Industrial Hygiene Division. These units will comprise:

A. Field operations section.—The present staff of this section should be maintained to provide for consultation services in the various professional fields with consultants attached to the district offices of the Public Health Service. (Practical assistance in conducting studies of special hazards will be covered in the proposed budgets of the medical, engineering, and statistical units.)

B. Dermatoses section.—The Dermatoses Section is concerned not only with dermatoses occurring in industry as a result of occupational exposure to conditions or substances capable of affecting the skin, but also with the prevention of dermatoses among the general public from substances potentially capable of, or actually responsible for, widespread outbreaks of dermatitis. The importance of occupational dermatitis has been so impressed on physicians, safety engineers, manufacturers, labor unions, and others that the demands for services from this section far outstrip the amount of work than can be done by the present personnel. It is anticipated that after the war these demands will increase, not decrease. Present personnel, already overtaxed and not able to keep up with the demands, will have to be considerably increased.

C. Medical unit.—The Medical Unit acts as a consultative service and makes epidemiologic investigations relating to the medical phases of industrial hygiene investigations in industral establishments. These investigations are usually made jointly with such other professionally trained personnel as engineers, chemists, and physicists, needed to cope with the problem at hand. The medical staff concerns itself with the physical qualifications of workers and the manifestations of occupational disease, whereas the other specialists point their investigations at environmental factors.

The following projects are proposed for this unit:

1. Independent studies or studies in cooperation with other Federal agencies: These studies would be similar to the present study of health hazards in welding operations being performed in cooperation with the United States Maritime Commission. An example of a study in this classification would be a restudy of anthracite mine workers and their working environment. Ten years have elapsed since the field study reported in Public Health Bulletin No. 221. At that time 23 percent of 2,711 workers had anthracosilicosis. The purpose of the restudy of the same miners and mines would be to determine: (1) What has happened to those affected with the diseases and (2) whether the disease has become manifest in additional mining personnel and how effective engineering means of control have been. It would require careful clinical study of those mine workers who have been forced to discontinue this type of employment. Information gained from the study should aid materially in defining accrued liability which has always been a moot point in arriving at an equitable level of compensation for those legitimately disabled. This project could and probably should be worked out jointly with the United States Bureau of Mines.

2. Projects in cooperation with State and local industrial hygiene units:

(*a*) Studies of various occupational disease problems: Here would be included a study of dust conditions in bituminous coal mines and a study of the coal byproducts (chemical) industry in West Virginia. Among other diseases requiring investigation are poisonings by metals, gases, and fumes, impaired hearing (due to noise), and impaired vision (due to faulty illumination).

(*b*) Studies in applied gerontology: In the beginning, these studies, to be undertaken in cooperation with State and local units of industrial hygiene, should be pointed at heart disease, tuberculosis, arthritis, diabetes, and cancer.

(*c*) Evaluation of medical services in industries: This will require a study of medical services provided in industrial plants with the object of developing standardized procedures depending upon the number of employees and the nature of the product or service.

D. Engineering Unit.—The Engineering Unit will serve as an advisory and fact-finding body. Through the Field Operations Section it will assist States and other governmental agencies in conducting investigations which will be quite varied in character, as well as make special investigations of problems having general interest. Special studies will deal with (1) industrial ventilation, (2) new toxic substances, (3) studies of threshold limits of toxic substances, and (4) investigations of need for labeling toxic materials. Finally, since many States are confronted with problems with which they are unable to cope, the Engineering Unit should have experienced personnel available to aid them with such special problems.

E. Statistical Unit.—The Statistical Unit will develop along the following lines in response to the interest in the statistical aspects of the relationship of the health of the worker to his environment:

1. Cooperative work and consultation with industry, industrial health agencies, and various individuals on statistical questions pertaining to health.
2. Studies on disabling sickness among industrial workers, with the object of reducing lost time.
3. Dissemination of procedures for the recording, reporting, and study of disabling sickness among industrial workers.
4. Studies on workmen's compensation and on the standardization of occupational disease reporting.
5. Guidance in the development of sickness benefit schemes for industrial workers.
6. Studies on statistical methodology for the purpose of aiding investigators in the field of public health to draw sound conclusions from their observations.

F. Chemical Unit.—The Chemical Unit activities include (1) analysis of air samples and materials collected by field personnel during investigations (2) analysis of samples submitted by State and local industrial hygiene services which have inadequate facilities, (3) investigation and development of field and laboratory methods of analysis, (4) field consultation service to State and local industrial hygiene services through the Field Operations Section, and (5) standardization and referee work on laboratory methods.

Other activities, including hospitalization: Field investigations of the Industrial Hygiene Division will uncover cases of occupational poisonings and occupational infections, as well as occupational deformities, which should be hospitalized for study of symptomatology and treatment. This study should be performed in cooperation with the Marine Hospital Division of the Bureau of Medical Services and the Industrial Hygiene Research Laboratory of the National Institute of Health.

II. Grants to universities

The increased demand for trained industrial hygienists, not only in the field of engineering, but also in the fields of medicine, nursing, and dentistry, cannot be met at the present time. Moreover, the number of trained personnel who will be released from the armed services for postwar duty will be limited.

At the present time there is only one university giving extensive postgraduate training in industrial hygiene and about five others giving limited instruction in each of the various fields. The postwar proposals contained in this report and the known demands of industry indicate a minimum requirement of a training program for at least 300 professional personnel per year. Consequently, it is proposed to subsidize postgradute courses in 6 to 10 strategically located colleges and universities, each school to receive $50,000 to $75,000 per annum for 10 years.

III. Grants to States

Establishment of minimum industrial hygiene services in the 10 States which now have no such services, strengthening of organizations in those units now established, and decentralization of industrial hygiene services at district, city, and county health department levels would require a minimum annual allotment of $2,450,875.

The estimates of necessary personnal have been based on allowing 1 professional worker for each 100,000 in the labor force and 1 clerk for every 3 professional workers—with reasonable adjustment based on the total labor force.

Funds necessary for grants-in-aid for development of industrial hygiene programs in State and local health departments

		Dollars or persons
1943–44 appropriation		$1, 239, 064
State, local, and other	$636, 529	
Title VI	602, 535	
State personnel:		
Professional		240
Clerical		95
Necessary personnel:		
Professional		560
Clerical		193
Needed new personnel:		
Professional		320
Clerical		98
Additional funds needed (exclusive of present title VI funds)		$1, 848, 340
Salaries	$1, 311, 340	
Equipment	220, 000	
Travel	317, 000	

Industrial Nutrition Service

DEVELOPMENT OF NUTRITION PROGRAM FOR INDUSTRIAL WORKERS

Development of a nutrition program for industry has been an important wartime job. In August 1942 there was established within the Nutrition Division of the Office of Defense Health and Welfare Services of the Federal Security Agency a section to develop such a program. On March 6, 1943, the entire Nutrition Division was transferred to War Food Administration, by Executive order of the President, and became the Nutrition Programs Branch of the Office of Distribution of that agency. The Nutrition in Industry Section of the Nutrition Division became the Industrial Feeding Programs Division of the Civilian Food Requirements Branch, OD, WFA. These Federal Nutrition activities have been directed primarily toward increasing the productive efficiency of workers and speeding up production of war supplies. They have pointed the way toward a continuing peacetime program for the protection and improvement of the health of industrial workers

PROPOSED TRANSFER OF WAR NUTRITION FUNCTIONS TO PHS

After the war it would seem desirable to transfer these industrial nutrition programs from War Food Administration to the Public Health Service and to establish an Industrial Nutrition Service in the Industrial Hygiene Division of the Service. The initial step in this direction would be the transfer of the nutrition, health, and engineering functions of the Industrial Feeding Programs Division, together with the regional staff thereof, to the Public Health Service. The contemplated Industrial Nutrition Service would call for an annual budget of $260,000 (not included in this report), of which $55,000 would be used to foster research, largely through the National Institute of Health.

PLACE OF NUTRITION PROGRAM IN INDUSTRIAL HYGIENE

The nutrition of the industrial worker is basic to all industrial hygiene work. The nutritional status of the worker affects his liability to accidents, his resistance to disease and industrial toxic hazards, his morale and efficiency, and the length of his productive life. No industrial hygiene program can reach maximum effectiveness unless it provides for due consideration of the nutritional factors involved. Likewise, to be of most benefit to the workers, an industrial nutrition program must be an integral part of the health and safety programs being conducted in the plant and community.

PRESENT UTILIZATION OF INDUSTRIAL FEEDING FACILITIES

The foods that workers obtain from feeding facilities at their places of work have an extremely important bearing upon their nutritional status and health. However, at present (January 1945) at least 60 percent of the workers do not patronize such facilities, and those that do use them generally do so for only one meal a day. An intensive program is indicated to increase the adequacy and the extent of utilization of on-the-job food services, but it is probable that at least 40 percent of the workers will continue to depend upon home-prepared lunches or other facilities for their midshift meals, in the foreseeable future.

COOPERATIVE ACTION OF MANY AGENCIES NEEDED

An industrial nutrition program therefore, to be most effective, must be set up to influence the food consumption of the worker (and his family) at meals obtained outside of, as well as in, his place of work. To function in this manner requires the active participation of State and local health agencies as well as of private health and nutrition groups. The United States Public Health Service enjoys the confidence and cooperation of such bodies to an extent not possible with any other agency of the Federal Government.

HUMAN NUTRITION A NEW SCIENCE

Human nutrition is a relatively new science. There are many gaps in our knowledge, and much of the available information must be subjected to careful study and critical analysis before attempts at application are made. Particularly where the food requirements of workers are concerned is there need for extensive research. This was forcibly brought to the attention of the nations of Europe and of the United States during the last great war and again during the present one. At the onset of neither war were we prepared with the information needed to act promptly and effectively.

THREE MAJOR TASKS OF INDUSTRIAL NUTRITION SERVICE

One of the three major tasks of an industrial nutrition service during peacetime should be to conduct, stimulate, sponsor, and compile the results of research on the food requirements of, and methods of feeding, occupational groups and the effects of nutrition and food services upon industrial efficiency. Work of this type requires the services of physicians, physiologists, nutritionists, and engineers. It requires close working relationships with research groups throughout the country. It is a function which the United States Public Health Service is well equipped to perform.

The other two major tasks of an industrial nutrition service in peacetime are (1) to disseminate information on nutritional, sanitation, and food service requirements and render technical advisory services to States and industry; and (2) to recommend, advise on, and assist with, nutrition education programs for workers and their families.

WARTIME ACCOMPLISHMENTS

The Industrial Feeding Programs Division of the Office of Distribution has done an excellent job in assisting industry and labor with problems arising in connection with the installation and operation of on-the-job food service facilities. It has done considerable educational work with plant management, food service managers, and labor. The fact that industrial feeding is now accepted by industry and labor alike and that the importance of the nutritional status of the worker is recognized not only by these groups but by industrial physicians and all governmental agencies is due in a great measure to the work of this Division. The Chief of the Division is a commissioned officer of the United States Public Health Service, on loan to the War Food Administration. He has been in charge of this work since its inception in the Office of Defense Health and Welfare Services, August 1942. Within the limitations set by the larger unit in which he works, program policy and the organization and personnel of the divisional staff are his responsibility.

PRESENT AND FUTURE PROBLEMS

The problem now and in the future is to obtain the optimum consumption of the proper foods needed to protect the health and maintain the morale of workers and their families. This is a health problem, pure and simple, although it does have definite implications for agriculture in that a health-conscious, better-fed Nation means a high level of food consumption and greater economic returns to the farmer.

Tuberculosis Control

EXTENT OF POSTWAR TUBERCULOSIS PROBLEM UNPREDICTABLE

Postwar planning estimates must, of necessity, be very general because of the inability at this time to give reliable estimates as to the extent of the tuberculosis problem after the war.

It is suspected that the scope of the problem will increase for the first 5 years after the war due to shifts in population that will tend to bring infected groups in close contact with uninfected groups. The full weight of the effect of war on tuberculosis mortality and morbidity will not be felt probably until 2 years after the termination of hostilities, if the last war's experience may be used as a reliable index.

LEVELING OFF AFTER 5 YEARS IF CONTROLS ARE EFFECTIVE

A leveling-off process after 5 years may be expected if control measures are continued in force and augmented during the initial years after the war. Because of the fact that no specific prevention or cure is known against tuberculosis, research on a material level should be increased each year as competent workers become available and as States are able to develop research facilities.

These predictions are general in nature because no scientific data are at present available to substantiate these preliminary estimates. During 1945 and 1946 our newly expanded program of tuberculosis control will make such data available.

EFFECT OF NEW SCIENTIFIC DISCOVERIES ON TUBERCULOSIS CONTROL PROGRAM

It should be noted that our whole thinking on tuberculosis control may be changed within the next 2 years. There will be the changes in distribution of early and advanced cases as a result of mass radiography of the chest which has been made possible by recent developments in photofluorography. Furthermore, intensification of research in chemotherapy may yield a therapeutic agent that will help to arrest or even cure the disease. If such a discovery is made the need for sanatorium facilities will be sharply affected.

FACILITIES CONSTRUCTION PROGRAM

Realizing that any estimates on hospital needs for tuberculous patients may need radical revision on short notice, it may be suggested tentatively on the basis of present knowledge of morbidity and mortality from tuberculosis, and of current data on hospital care and probable number of obsolete beds, that new construction costing, roughly, $250,000,000 to $300,000,000 may be needed in the first 5 years after the war, the peak being in the third year. It is assumed that at least half of this cost will be met by the Federal Government. Maintenance and operation costs might be expected to rise from $10,000,000 to $50,000,000 a year during the first five postwar years, leveling off at about $17,000,000 a year in the second 5-year period. The operating service program might amount to $20,000,000 the first year, $10,000,000 in the fifth, and $5,000,000 a year during the second 5-year period. The entire cost of this service program would be met by the Federal Government.

Present personnel and space used in district offices and estimated requirements in 1945, 1946, and selected postwar years

District office	1945		1946		First postwar year		Second 6 postwar years		Tenth postwar year	
	Employees	Space	Employees	Space	Employees	Space	Employees	Space	Employees	Space
Total	311	46,937	503	92,950	629	108,350	752	130,300	642	113,650
New York, No. 1	41	4,860	76	14,900	94	17,600	112	20,300	96	17,900
Washington, No. 2	18	2,970	71	10,650	98	14,700	124	18,600	106	15,900
Chicago, No. 3	82	10,810	101	18,650	109	19,850	116	20,900	99	18,200
New Orleans, No. 4	51	9,000	88	16,700	107	19,550	126	22,400	107	19,550
San Francisco, No. 5	19	5,786	68	13,700	92	17,300	116	20,900	99	18,350
San Juan, No. 6	26	2,345	41	6,150	49	7,350	56	8,400	48	7,200
Kansas City, No. 7	21	3,292	------	------	------	------	------	------	------	------
Denver, No. 8 [1]	13	2,419	58	12,200	80	12,000	102	18,800	87	16,550
Dallas, No. 9	29	4,608	------	------	------	------	------	------	------	------
Hawaii, No. 10 [2]	5	(?)	------	------	------	------	------	------	------	------
Alaska, No. 11 [2]	6	847	------	------	------	------	------	------	------	------

[1] The Denver district, now designated as district 8, will become district 7 in the postwar consolidation. New Mexico from district 9 and Kansas and Nebraska from district 7 will become part of the Denver region.

[2] Will become part of the west coast territory.

Dr. SHEARON. I'll tell you what—I have sets of these pages. I didn't have time to assemble a set. It is quite a job, but I will do that and I think you will find in it a very valuable and constructive program, and I might say this: that in my consultant work with the Republicans I have followed this book, and I might say also Senator Taft has. He has had this. He took it home with him, he studied it and said, "That is a fine program. I think it should be implemented." I should think it would be of use for all the Senators.

This is a nonpartisan thing. This is directed toward the health of the country and the best utilization of public funds to attain the goals that I think all of us have in mind, and you will see here that there is this new program referred to for medical care. That would be a new thing for the Federal Government to do, and it would be on the grants-in-aid basis, the thought being there that if the Federal Government is going to do anything in the way of medical care for personal services, that you would spend that money to the best advantage and not spend too much if you poured it in at the bottom of the heap where a little money would do a lot of good. That was the reason for the suggestion. It started with only a hundred million. That seemed, as a matter of fact, in the Public Health Service like a lot of money, but now we deal in billions.

Senator MURRAY. Dr. Shearon, I understand then that S. 545 implements this program?

Dr. SHEARON. It implements part of it and the same way with some of the other bills that Senator Taft has introduced, the Cancer bill, S. 1130, and so on. Each one of them is directed toward some part of the over-all health program, and I might say this——

I think somebody testified yesterday—I guess it was Wilbur Cohen, who said he would draft any bill that he was asked to draft or any amendments to the bill, and was waiting until the Senators asked him to draft amendments.

I will not do that. I think a professional person has a very decided responsibility in regard to the drafting of legislation. I had Senator Taft call me in one day and ask me to draft a certain bill. It happened to be the Cancer Research bill to be drafted in a certain way, and I said. "I am awfully sorry, Senator Taft, but I can't do that." He said, "Why?" I said, "I don't think that would be a good way to do it. I don't think that would be a good scientific cancer research bill." He said, "Go ahead and draft it your own way," and I spent a good many months in getting expert opinion in the Government and outside of the Government in the preparation of S. 1130. So I think the professional consultant has real responsibility not just to do something somebody tells him to do, whether it is a Senator or the President of the United States.

When you have a responsibility you say, "These are the facts as I find them and I think this would be good or bad." I don't know whether Senator Taft agrees with me or not. When I turn in anything I say, "To the best of my knowledge this is the way that appears to be good for the public interest."

Senator MURRAY. You have disagreed with Senator Taft with reference to S. 545, haven't you?

Dr. SHEARON. Some phases, and I disagreed very strongly on S. 140, and I don't hesitate to say so. I also said to him with regard to some sanitation bills that came through that the Democrats definitely had much better bills.

Senator MURRAY. I won't interrupt you now, but I will ask you about this later.

Dr. SHEARON. Yes, Senator.

Senator SMITH. Will you continue, Doctor?

Dr. SHEARON. I have attended practically all hearings dealing with compulsory sickness insurance and related legislation since 1938. In addition, I have travelled extensively throughout the United States and the Islands of Hawaii, with a view to learning first hand something about the social and economic problems with which I have been working.

I trust that my experience in connection with the drafting of the bills now before this subcommittee and of predecessor bills may be of some service to you.

The problem stated: This subcommittee has now nearly completed the hearings on two bills, S. 545 and S. 1320, which deal with an extremely controversial issue. Dozens of witnesses have been heard. Reams of statistics and volumes of statements have been presented for your consideration.

You have been urged to act quickly, to do something before the Nation collapses from the disabling, often fatal, diseases that ravage our otherwise fair land. With equal ardor and persuasiveness you have been assured that our national health is remarkably good, that the United States compares favorably with the other nations of the world.

The assertions made by various witnesses cannot all be true. Nor could Congress, if it would, comply with all the conflicting proposals for action which have been made by proponents and opponents of the two bills now under discussion.

I shall endeavor to state briefly the nature of the national health problem toward which these two bills—S. 545 and S. 1320—are directed and the philosophy back of the proposals. Second, I shall give a few illustrations of the implications of the legislation. Third, I shall make some recommendations for your consideration in deciding what action should be taken.

Well, I didn't do that. I thought I would have time to give a résumé of the historical development of this national health legislation, but I didn't have time to write it. I can give it verbally.

The problem you are considering has been receiving more and more attention each year since President Roosevelt called the National Health Conference in 1938 and Senator Wagner introduced his first national health bill the following year. There has been increasing agitation for some sort of legislation that would provide Federal funds for governmental intervention—State, or Federal, or both—in the distribution of medical, hospital, and related health services.

The first question which the members of this subcommittee will have to decide is whether or not they are convinced that a serious health problem of national proportions exists.

As impartial judges of the evidence submitted, you will have the responsibility of deciding whether, first, the health of our Nation is at a low ebb; second, whether medical, hospital, and related services are inequitably distributed; and third, health and medical resources are unavailable to the majority of the population.

If you are convinced that such is the case it will be further necessary to decide whether the several conditions are so widespread as to constitute a national emergency of sufficient proportions to justify invoking the taxing power and the resources of the Federal Government.

Statistics and reports have been presented to convince you that our unmet health needs are Nation-wide, that States and localities unaided cannot cope with the problem, and that voluntary action by the people on their own behalf is futile and ineffectual.

Part of the problem, it is said, is that health personnel—physicians, dentists, nurses, and so forth—and health facilities—hospitals, health centers, and research centers—are poorly distributed.

The claim is made that cities are too abundantly supplied with health personnel and facilities while rural areas are undersupplied. You have been told repeatedly the draft rejections indicate that our national health is in a woeful state, that the health of our children has been neglected. Correction of these deficiencies, it is claimed, must be undertaken by the Federal Government.

On the assumption that Federal intervention is necessary in meeting the situation described, two types of legislation have been proposed. One—S. 545—is modest in scope. It would give financial assistance to the States through grants-in-aid distributed according to an objective formula based on the needs and fiscal capacities of the several States.

Administration would be on a Federal-State basis, the Federal Government setting standards, giving technical advice, and passing on State plans and programs.

The second type of legislation—S. 1320—calls for the creation of a system of medical care insurance as part of a national scheme of compulsory social security. It involves a taxation program not incorporated in the bill; it promises a wide variety of services for the entire population; and it inevitably raises a multitude of questions relating to the desirability of Nation-wide compulsory sickness insurance; or, as it is called, medical care insurance.

Briefly, then, this subcommittee must decide three things at the start. First, whether there is a national health problem calling for Federal intervention; second, whether any Federal legislation—one of these bills or some other bill—is called for at this time; and third, assuming that some legislative action is desirable, which type of legislation is best suited to American needs.

These are questions not to be answered lightly. Your decisions will have far-reaching effects. They will concern not only the health of the people, but our entire way of life and, I doubt not, the very form of government under which we live.

Similar questions have cropped up in most of the countries of the modern world. Legislative bodies in Europe, Asia, South America, and elsewhere have deliberated even as you are deliberating. For the most part they have chosen to enact laws of the same general pattern as that which is embodied in S. 1320. That is, they have chosen to adopt systems of national compulsory social insurance which included both medical benefits and cash benefits for sickness and permanent disability.

In reaching your decisions you will undoubtedly realize that the evidence presented has been far from objective. Conclusions and recommendations have been conflicting. The reliability of some of the reports presented by Federal officials and by nongovernmental witnesses has been questioned by responsible authorities. The credibility of some witnesses and the reliability of some interpretations has been attacked.

Some of the testimony has been of little value because the witnesses obviously were unfamiliar with the content of the bills in question, or were totally unaware of their administrative implications. Other witnesses were both unfamiliar with content and unaware of implications. Perhaps you may conclude that after all these hearings you still lack the basic knowledge needed to form an impartial judgment. You may decide you need more information, or let us say, better information; more light, less special pleading.

Let us now proceed to the philosophy and implications of the two bills.

S. 545 makes use of the time honored Federal grants-in-aid technique to assist the States in developing their own health programs. It amends the Public Health Service Act by adding some new sections and three new titles and by proposing a reorganization plan for Federal health and medical activities.

Senator SMITH. Doctor, let me interrupt. Did the passage of the bill last year take those sections out of S. 545, or were you incorporating those in an over-all bill in case we pass 545. Would you consider incorporating?

Dr. SHEARON. I don't think it makes too much difference as long as the same objectives are reached. This bill was written, I think, before the other bill came in, so that we would have an over-all picture. I might say, I think S. 545 has been much misunderstood. It was designed, shall we say, to plug some of the holes in the Public Health Law, some of the places where provisions for funds hadn't been put into the statute. For instance, the Cancer Research Fund had been given from year to year by Congress simply on the request of the Public Health Service. They themselves felt that there should be provision in their basic public health law for cancer funds.

That accounts for one of the sections in S. 545. Some people have said it is a hodge-podge bill, just a bit here and a bit there. They have asked what is it all about. There is reason for that appearance of being disconnected, namely, that we have a very fine basic public health law, but some parts in it were not complete. We were adding these parts, as for instance for dental research and medical care for the low-income groups. They have not been a Federal function, and weren't in the public health law. I don't think it makes very much difference whether you do it in one bill or in separate bills.

The provision which has attracted the most attention is that which provides $200,000,000 a year for 5 years for medical-care grants to the States. In this respect the bill takes the Federal Government into a new field of activity, namely, the provision of medical care for a certain portion of the population variously estimated at from 20 to 25 percent of the total.

For the purpose of sharpening the legislative issues presented by S. 545 and S. 1320, I shall concentrate on the medical-care provisions of the two bills because these are the most controversial, the most difficult to decide upon.

I think it is wise to perhaps point up these two issues rather than to become so diffuse with talking all about the sections that we would be pretty soon lost in the woods and couldn't really see the main issues.

S. 545 is, shall we say, a less terrifying bill than S. 1320. Indeed, it is so mild in appearance that its opponents have condemned it as inadequate and as a mere charity measure.

However, I believe that this subcommittee and the Congress as a whole might wish to ponder not so much the present mildness of the bill and its present preoccupation with persons of low income, but rather the broad implications of the utilization of general Federal revenues to pay part of the medical care bills of a loosely defined segment of the population.

This segment is sometimes called the medical needy; the bill nowhere defines who are persons in the low-income group and who are medically needy. That decision is left to the States. Indeed, it would probably devolve on local welfare workers or health officers to make individual, subjective decisions as to who would be entitled to the promised aid.

Congress did the same thing when it passed the Social Security Act without defining who were the needy persons entitled to old-age assistance and other aid. It is not difficult to see that administratively it might be difficult to decide who is medically needy.

Perhaps nearly everyone in the course of a lifetime is medically needy at least once. Even a person with a substantial income might qualify for aid under S. 545 if he or a member of his family were the victim of one of the more expensive chronic ailments such as cancer, diabetes, or infantile paralysis, or if the costs of an expensive operation had to be met.

Thus it must be evident that S. 545 might be opening the door to almost universal Federal aid from general revenues to pay the costs of medical care, hospitalization, and related services. True, that would not be the intent of the bill, and at the start funds would be limited to $200,000,000 a year. Congress would hold the purse strings.

But pressure from administrative agencies, from nongovernmental vested interests, and even from Members of Congress seeking popular approval and political advancement might ultimately carry us a long way toward Federal control of medicine and development of a too powerful bureaucy.

I do not say that such would be the case. But it is a possibility that should be weighed by this subcommittee. Similar expansion has occurred, say, in the programs of the Children's Bureau with the result that there is now before Congress a bill—S. 1714—that would nationalize medicine for all mothers during the maternity period and for all children up to the age of 18 years. That bill calls for grants-in-aid but it would be meshed into a national compulsory insurance law when and if one were enacted.

The more I study the course of legislation and of Federal operating programs the more I am impressed by the fact that great changes in our way of life are brought about by laws which begin modestly.

They appear to be in the public interest. They do not involve vast sums or large administrative staffs. But after a few years, appropriations and staffs grow to amazing proportions. Budget requirements never decline. Staffs dig in and seek to perpetuate themselves.

A modest, innocuous Federal program, once thrown into the bureaucratic hopper, is certain to expand unpredictably and perhaps deleteriously. Therefore, in embarking on a whole new field of Federal action, namely, the field of personal health services for individuals, it would be well to look ahead a decade to see how such a program as the one proposed would be likely to develop.

The philosophy and implications of S. 1320: When we turn to S. 1320, we find an entirely different type of bill in the main, although it, too, makes use of grants-in-aid for personal health services for some segments of the population. But the distinctive feature of S. 1320 is that it calls for establishment of a Federal system of compulsory medical care insurance as part of a comprehensive scheme of national social security.

The significance of the bill cannot be appreciated if it is viewed out of its context of omnibus compulsion for the entire population. This subcommittee is thus brought face to face with the multitudinous questions surrounding the entire social security program.

For more than a decade now we have been living under the Social Security Act as passed in 1935 and repeatedly amended. I believe this law is the most important piece of domestic legislation that has been enacted by the Congress of the United States up to this time. It is significant not so much for what it does initially as for the long-range effect it will surely have unless Congress blocks further expansion.

Turning to S. 1320, we see that medical-care insurance is to be made part of a comprehensive national social security program. The blueprint for the over-all social security plan is best seen in the 1945 Wagner-Murray-Dingell bill, S. 1050, which furnishes the total legislative plan for the several cash benefits programs and for certain free services, such as medical care and hospitalization.

That bill was referred to the Finance Committee and there shelved but it is worthy of the most careful study by this committee.

You might feel that a bill that had been referred to another committee and had not come out of that committee, and that furthermore, had been introduced in a prior Congress, was a dead bill which you didn't have any reason to consider it. But it does give you, after all, the over-all picture that was in the mind or minds of the people who drafted that over-all plan. What we are now getting in these various bills like S. 1320 and other bills that come through is piece-meal sections of that whole thing, but you get a much better picture if you look at S. 1050.

Senator DONNELL. You think if the proponents of them succeed it will ultimately work out substantially as the over-all picture shown in S. 1050?

Dr. SHEARON. That's correct. I don't mean in every detail, but as the bills come through you much see them as a part of an enormous jigsaw puzzle. The people who drafted say the S. 1050 had in mind the total puzzle before it was cut up by the jigsaw, and now the pieces have all been mixed up and they look unrelated. Each bill by itself you might say is a good bill. If we have cash benefits for sickness, for disability, or for more old-age benefits, it might appear good; but by the time you put all those pieces together and have the total jigsaw puzzle formed, you see something that is very comprehensive and one should look at it before it is cut up into jigsaw pieces.

When the S. 1050 was introduced I prepared a digest of the bill for the Minority Conference and I now wish to incorporate the digest at this point. I believe I am in the embarrassing position of not having brought a copy with me. If I had additional copies I would have given one to each Senator. It is a digest of S. 1050 which I think might be helpful to the committee. Since I can't show it to you, I don't want to give you something sight unseen.

Senator SMITH. You want it to appear at this point or at the end of your remarks?

Dr. SHEARON. Well, I had a number of exhibits. I don't care where they appear. The exhibits would probably go in at the end of my statement.

Senator SMITH. I think it ought to be consecutive rather than to have it by reference appear at the end of your statement.

Dr. SHEARON. I have a list of the exhibits on page 38 on the last page of my testimony; a list of the exhibits that I would like to have introduced, if it is agreeable to the committee. Also at the same time I should like to introduce a digest of S. 1606 which is part of S. 1050.

(The digest referred to is as follows:)

DIGEST OF THE FIRST 1945 WAGNER-MURRAY-DINGELL BILL (S. 1050; H. R. 3293)

(The views expressed are those of the writer and do not necessarily represent the opinions of any member of the minority or of the minority as a whole)

(Marjorie Shearon, Ph. D., research analyst, conference of the minority, November 28, 1945)

BROAD FRAMEWORK OF THE BILL

In this omnibus bill the Social Security Act, as amended, is virtually rewritten and the whole social-security program is reorganized by—

(1) Creating a highly centralized national social insurance system;

(2) Replacing present assistance provisions for dependent children, the aged, and the blind with a comprehensive public assistance program for all needy persons;

(3) Providing for a 10-year program of Federal grants and loans for construction and expansion of hospitals, health centers, and related facilities;

(4) Providing variable grants to States from general revenues for maternal and child health and welfare services;

(5) Establishing in the Social Security Board an expanded and strengthened national system of public employment offices; and

(6) Providing Federal grants to States from general revenues for a great expansion of public health services.

The bill centralizes tremendous power in the Social Security Board by—

(1) Creating the national social insurance trust fund, which, for all practical purposes, would be largely controlled by the Social Security Board;

(2) Transferring from the Bureau of Internal Revenue to the Social Security Board authority to collect all social-security taxes or to designate the collecting agency;

(3) Setting up a new Federal unemployment insurance system to administer unemployment benefits and the new temporary disability insurance benefits (the latter comprising a Federal compulsory sickness insurance cash benefits scheme), the consolidated system to be administered by the Social Security Board;

(4) Inaugurating a disability insurance cash benefits as an extension of the old-age and survivors insurance system, the entire scheme to be operated by the Social Security Board;

(5) Broadening the public assistance programs already under the Board into a single comprehensive general assistance program to be administered by the Board through variable grants-in-aid;

(6) Subordinating the Public Health Service to the Social Security Board through administrative and fiscal devices; and

(7) Establishing a National Advisory Social Security Policy Conucil, which the Social Security Board itself would appoint, to formulate broad policies and to make findings and recommendations concerning: Administration of the social insurance system; administration of medical, hospitalization, and related benefits; adequacy of benefits; methods of postwar financing; etc.

The legislative proposals made in S. 1050 relate to three large fields of social action. The bill:

I. CREATES A NATIONAL SOCIAL INSURANCE SYSTEM

A. Coverage

1. All employees in industry and commerce (except railroad workers), agricultural, and domestic workers, and employees of nonprofit institutions eligible for: (*a*) Retirement, extended disability, and survivors' benefits; (*b*) unemployment and temporary disability (i. e., sickness) cash benefits; (*c*)"personal health service" (i. e., medical care and hospitalization) benefits.

2. All self-employed persons (farmers, small-business men, professional persons) and, by voluntary compact, employees of State and local governmental units not having pension systems for such employees eligible for all benefits specified in item A 1 above except unemployment and temporary disability.

3. All servicemen in active military or naval service since September 1939, by extending military service credits of $160 a month, eligible for all insurance benefits specified in item A 1 above.

B. Administration

1. The expanded national social insurance system would be administered by the Social Security Board through a Nation-wide network of combination social-security and employment offices. The number of such offices would presumably be many thousand, since there would be local staffs in every community to administer the several income-maintenance or cash benefit programs (under both the insurance and the assistance provisions of the bill) and the employment services.

2. "Personal health service" benefits (i. e. medical and hospital care) would be administered by the Public Health Service subject to fiscal and administrative control by the Social Security Board. The line of authority would pass from Public Health Service to State health offices down to county and municipal health offices but jurisdiction would not be clear-cut since the policing of the compulsory sickness insurance scheme (case benefits and medical benefits) would presumably be the responsibility of the Social Security Board by virtue of its control over the insurance fund.

3. The Social Security Board, instead of the Bureau of Internal Revenue, would collect all the social security taxes. There would be a single wage report.

4. There shall be established a Federal social insurance trust fund into which shall be paid: (*a*) All social security pay-roll taxes; (*b*) Federal social security trust funds previously established as separate accounts in the Treasury of the United States; (*c*) the annual Federal subsidy to cover the deficit for the insurance programs; (*d*) the annual Federal appropriation to pay for benefits for recipients of public assistance; (*e*) payments made through voluntary compacts with respect to State and local employees; (*f*) payments made with respect to noninsured groups such as beneficiaries under workmen's compensation, United States Employees' Compensation cases and crippled children; (*g*) interest on bonds invested in Government obligations; and (*h*) penalties and fines.

5. The Federal social insurance trust fund shall be managed by three trustees: the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board. The funds are to be invested in Government obligations and are to be used solely for the benefits specified and for administration of the system.

6. The Social Security Board is authorized to appoint a National Advisory Social Security Policy Council of unspecified size with representatives of employers, employees, and the public. This Council may, inter alia, formulate policies, review administrative operations, and make findings and recommendations concerning: coverage, administration of medical, hospitalization, and related benefits, adequacy of benefits, and methods of financing. There are no statutory representatives of the medical profession on this top policy Council.

7. The Surgeon General is authorized to appoint a small National Advisory Medical Policy Council of 16 members with limited powers. The language of the bill is such that the entire Council could be made up of nonmedical persons.

C. Liberalization of present old-age and survivors insurance benefits by—

1. Inclusion of extended disability protection for workers disabled 6 months or more (new benefit);

2. Increasing retirement and survivors' benefits through modification of the benefit formula; minimum benefit increased from $10 (present) to $20, maximum family benefit increased from $85 (present) to $120;

3. Increasing from present $14.99 to $25 the amount which beneficiary may earn without having his benefits suspended;

4. Reducing the age at which women may receive retirement benefits from 65 years (present) to 60 years;

5. Providing a lump-sum benefit equal to six times the primary benefit in all cases where the deceased individual was insured at the time of death.

D. Establishment of Federal unemployment and temporary disability (sickness) benefits

1. Weekly benefits for workers unemployed or temporarily sick (minimum $5 maximum $20 for single worker; maximum $30 for worker with dependents); benefits geared to previous wages.

2. One week waiting period in a year for unemployment, one week for disability.

3. Benefits payable for 26 weeks of disability or unemployment in a year (unemployment benefits may be payable for 52 weeks if funds are available).

4. Maternity benefits payable to married women workers for 6 weeks before and 6 weeks after delivery.

E. Establishment of "personal health service" (i. e. medical care and hospitalization) benefits as part of the benefits of the Federal compulsory sickness insurance scheme (see D above for sickness cash benefits)

1. Those eligible for medical benefits are: (*a*) Workers, their wives, or disabled husbands; (*b*) workers' children under 18 or any age if disabled; (*c*) workers' aged dependent parents; (*d*) persons receiving retirement, extended disability, and survivors' benefits; (*e*) any person on whose behalf appropriate social security taxes have been paid by a public agency. This provision would make it possible for welfare agencies to make contracts with the Social Security Board for medical care for public assistance recipients, and for similar contracts to be made by the United States Employees' Compensation Commission, the Veterans' Administration, Workmen's Compensation agencies, and other public agencies.

2. Benefits include: (*a*) Services furnished by a general practitioner to be selected from among physicians within limited areas who have contracted with the Government and agreed to become insurance doctors working under Federal rules and regulations; (*b*) specialist services (if recommended by the general practitioner of the insurance system, laboratory services, and necessary hospital care up to 60 days a year (120 days if funds permit) for each member of the family; (*c*) dental and home nursing services limited because adequate services would cause a heavy drain on the insurance funds;

3. Physicians to be paid on a fee-for-service, capitation, or salary basis, according to majority vote in each community.

4. In order to conserve insurance funds, insurance patients may be required to pay physicians for first, second, or all home visits.

5. The principle of "economy of administration" is incorporated in the bill. That is, insurance physicians must prescribe in accordance with insurance economy regulations with primary consideration for the insurance funds.

6. Grants shall be made for medical research and education and training of health and medical personnel.

F. Compulsory Federal social-insurance taxes

1. Employers and employees shall pay taxes of 4 percent on wages up to $3,600 a year (2½ percent for State and local governments and their employees covered by voluntary compact).

2. Self-employed persons (farmers, professional persons, small-business men) shall pay taxes of 5 percent of earnings up to $3,600 a year.

3. Government subsidy from general revenues authorized to meet deficits for the insurance schemes.

4. Government to pay from general revenues entire cost of (*a*) military wage credits; (*b*) dental and home nursing benefits; and (*c*) all "personal health service" benefits (i. e., medical care and hospitalization) for beneficiaries who became insured before bill goes into effect.

II. ESTABLISHES A NATIONAL SYSTEM OF PUBLIC EMPLOYMENT OFFICES

A. The United States Employment Service, originally established in the Department of Labor by the Wagner-Peyser Act (48 Stat. 113, approved June 6, 1933), and transferred to the Social Security Board under the President's Reorganization Plan No. 1 (approved June 7, 1939), and again transferred to War Manpower Commission by Executive Order 9247, September 17, 1942, would be made into a permanent national system of public employment offices under jurisdiction of Social Security Board.

B. Repeals title III of the Social Security Act and the Wagner-Peyser Act.

III. PROVIDES FOR COMMUNITY SERVICES AND FACILITIES FINANCED FROM GENERAL REVENUES

A. Provides for creation of a unified public assistance program for all needy individuals, to be administered by the Social Security Board.

1. Provides for variable grants to States, ranging from 50 to 75 percent of the total expended, based on State's per capita income.

2. Provides for Federal sharing of State costs, on variable grant basis, for money payments to any needy individual (without the present maxima).

3. Authorizes Federal matching on variable grant basis of costs to States for medical services for recipients of public assistance, and—

4. Provides that States may exempt any amount up to $20 per month from the income of an individual applying for assistance.

B. Makes inoperative titles I, IV, and X of the Social Security Act providing for aid to the aged, aid to dependent children, and aid to the blind, respectively.

C. Provides increased Federal grants for crippled children and for maternal and child health and welfare under title V of the Social Security Act administered by the Children's Bureau of the Department of Labor.

1. State plans must provide that programs be in effect in all political subdivisions immediately for services for crippled children and by 1955 for maternal and child health and welfare programs.
2. Federal Government to pay from 25 to 75 percent of amount State spends; States with lowest per capita income to receive maximum aid.

D. Provides increased Federal grants-in-aid to States for expanded public health programs to be administered by the Public Health Service.

1. State plans must provide that programs be in effect in all political subdivisions by July 1, 1949.
2. Federal Government to pay from 25 to 75 percent of amount State spends for public health programs; States with lowest per capita income to receive maximum aid.

E. Provides grants-in-aid to States for surveys of need for hospitals, health centers, and related facilities and for construction and equipment thereof (sec. 2 of S. 1050 is similar to the Hill-Burton bill S. 191).

1. Public health law (58 Stat. 682) is amended by addition of new title that would bring administration of hospital construction program under jurisdiction of Public Health Service.
2. Authorizes $5,000,000 appropriation for grants to States for 50 percent of cost of survey of needs.
3. Authorizes $50,000,000 appropriation for fiscal year 1946 and $100,000,000 annually thereafter for 9 years for hospital construction grants; $5,000,000 appropriation authorized for State administrative expenses in fiscal 1946 and open-end appropriation for same purpose thereafter for 9 years.
4. Grants to be made to States, localities, or private (i. e., sectarian and nonsectarian) nonprofit agencies for construction and equipment of hospitals, health centers, etc.
5. Federal construction grants shall range between 25 and 50 percent of cost of construction, but grants for individual projects may be supplemented by loans up to 25 percent of the cost of the project. States with lowest per capita income shall receive maximum grants.
6. Surgeon General is to give priority rating to projects in each State.

DIGEST AND CRITIQUE OF THE SECOND 1945 WAGNER-MURRAY-DINGELL BILL (S. 1606 AND H. R. 4730)

(The views expressed are the personal views of the writer and do not indicate any position taken by the Republican conference or by the Republican members of the Senate Committee on Education and Labor)

(Marjorie Shearon, Ph. D., research analyst, conference of the minority, January 15, 1946)

CHIEF PROVISIONS OF S. 1606

The new Wagner-Murray-Dingell bill, introduced in Congress on November 19, 1945, comprises certain sections of the omnibus W-M-D bill (S. 1050) introduced earlier this year. The bill provides for a national health program to include (1) a number of community-wide health services and (2) medical care and hospitalization, so-called "prepaid personal health service benefits," for workers and their dependents.

Community-wide health services.—Community-wide health services are to include (1) expanded public health services, (2) maternal and child health and crippled children's services, and (3) medical care for the needy. The Federal administrative agencies for these three groups of services are to be the United States Public Health Service, the United States Children's Bureau, and the Social Security Board, respectively.

The Federal Government is to aid the States through variable grants-in-aid for these community-wide services. Grants from Federal funds will range from 50 percent to 75 percent of what a State spends for the three programs. Maximum Federal aid will go to the States with the lowest per capita income.

In order to obtain Federal aid States must submit plans to the respective Federal agencies having administrative responsibility. Such plans must provide that programs shall be in effect in all political subdivisions of the respective States: (1) By July 1, 1949, for public health programs; (2) within 10 years after date of approval of first State plan for maternal and child health services; and (3) immediately, for medical care of needy persons.

Public health services.—State plans for public health must provide, among other things, that public-health services within the several States shall be extended and improved so that they shall reach "nationally accepted standards of adequate public health services." Such plans must also provide for cooperation and, "when necessary, for working agreements" between the State health agency and other "public agencies concerned with welfare, assistance, social insurance, workmen's compensation, labor, industrial hygiene, education, or medical care."

Maternal and child health services.—State plans for maternal and child health services and for crippled children's services must provide that the services and facilities furnished shall be available to all mothers and children in the State or locality who wish to have such services. There is no family income limitation as a restriction on eligibility.

Medical care of needy persons.—State plans for medical care of needy persons to be approved by the Social Security Board must provide for financial participation by the State, must be in effect in all political subdivisions of the State, and must meet in full the need of individuals throughout the State. A State plan may not impose any citizenship or residence requirements or exclude recipients of Public Assistance under the Social Security Act in determining eligibility for medical care, but it must require a means test in determining such eligibility.

Medical care of needy persons may be provided by State or local agencies or through arrangements with the Surgeon General. In the latter case, the State may pay into the Federal Treasury sufficient sums to pay for the medical care of the needy. Such care would be furnished under the "prepaid personal health service benefits" program described below.

In administering the medical care program for the needy the Social Security Board is authorized to enter into agreements with the Surgeon General and the Chief of the Children's Bureau so that the Board may coordinate all the medical care programs for workers and their dependents, for mothers and children, and for the needy.

Prepaid personal health service benefits (compulsory sickness insurance).—The second part of the national health program proposed in S. 1606 relates to provision of medical care for workers and their dependents and for persons already receiving retirement and survivors' benefits. Dependents include wives of workers, disabled husbands, workers' children under 18 or children of any age if disabled, and aged dependent parents of workers. Medical benefit under this compulsory Federal medical care and hospitalization plan may also be obtained for other persons, such as the needy, those entitled to workmen's compensation benefits, veterans, State and local governmental employees, crippled children, and others on whose behalf a public agency had made equitable payments into the Federal Treasury. Such payments would be credited to the personal health services account. The persons covered under this scheme are all employees in industry and commerce (except railroad workers), agricultural and domestic workers, employees of nonprofit institutions, and all self-employed persons (farmers, professional persons, and small-business men).

Benefits under this program would include services by general practitioners and specialists, dental and home nursing services, laboratory services, and necessary hospital care up to 60 days a year for each member of the family, or 120 days if funds permit. Dental and home nursing services may be limited in scope.

Any physician, dentist, or nurse legally qualified by a State to furnish any of the services defined as personal health services in this bill shall be qualified to furnish such services, except that the Surgeon General is authorized to designate who shall be specialists or consultants and who shall be entitled to receive special rates of payment as specialists.

Persons entitled to receive general medical or general dental benefit are permitted to select a practitioner or group of practitioners from among those in each local area who have agreed to enter into a contract with the Federal Government to furnish services in accordance with rules and regulations to be issued by the Surgeon General. Services of specialists or of consultants ordinarily will not be available except on the advice of the general practitioner.

The Surgeon General will pay general medical and dental practitioners on a fee-for-service, capitation, or salary (full- or part-time) basis, or on a combination of these. The method of payment in any locality will be decided by a majority of the practitioners in the area, but the Surgeon General, in paying practitioners who do not elect the majority method, may also make payments by any of the other methods listed. Specialists and consultants are to be paid on a per session, fee-for-service, per capita, salary, or other basis, or combinations thereof, according to agreements between the Surgeon General and the specialists and consultants.

In any local area where payment of general practitioners is on a capitation basis, the Surgeon General is required to make per capita payments to all cooperating practitioners for all persons who are entitled to medical benefits but who, after due notice, have failed to select a practitioner from among the listed or panel doctors in that area. That is, persons eligible for benefits will be paid for whether or not they use the services of the doctors on the Government list.

Every individual who is entitled to medical, hospitalization, and related benefits "may be required by the physician, dentist, or nurse furnishing such benefit to pay a fee with respect to the first service or with respect to each service in a period of sickness or course of treatment." Other limitations are authorized as punitive measures to prevent or reduce abuses.

There is created on the books of the Treasury of the United States an account to be known as the personal health service account. Congress is authorized to appropriate to this account such sums as are necessary to finance the benefits, payments, and reimbursements provided in this title of the bill. The Federal appropriation is to be made up of several parts, including an amount equivalent to 3 percent of the wages of employed persons and of the earnings (up to $3,600 of the self-employed; sums from general revenues to cover expenditures for dental and home nursing services; sums from general revenues to pay for medical care and hospitalization and related services for retired and survivor beneficiaries of the social insurance system who became insured before the bill goes into effect; and reimbursements made on behalf of noninsured persons (the needy, workmen's compensation cases, etc.).

The Surgeon General is authorized to make grants-in-aid for medical education and research.

While Senator Wagner in introducing the bill stated that the method of financing the national health program would be left to the Congress, the benefit structure for the personal health services program is practically identical with that in S. 1050 which calls for a system of compulsory sickness insurance financed from pay-roll taxes and general revenues.

NATIONALIZATION OF PHYSICIANS INEVITABLE UNDER S. 1606

When Senator Wagner introduced the omnibus social-security bills, S. 1161 in 1943 and S. 1050 in 1945, they were referred to the Finance Committee as taxing measures. Hearings were not called on either bill. In order to obtain early hearings on the medical-care provisions of the comprehensive bills, Senator Wagner lifted the public-health and medical-benefits sections of S. 1050 from their setting and incorporated them in a new bill, S. 1606, which he introduced on November 19, 1945. This bill fails to show directly the connection with a compulsory sickness insurance scheme, but the second title, euphemistically called prepaid personal health service benefits, is nothing more nor less than the medical-benefits provisions of a Federal sickness insurance program.

Expansion of public-health services; authorization of open-end appropriations.—Senator Wagner in presenting this bill starts by enlarging the presently accepted community-wide health services. Here he is on safe ground. He confirms existing programs and appropriations for the control of tuberculosis and of venereal diseases. For additional health services, such as public health nursing, industrial hygiene, mental hygiene, etc., he proposes, instead of the present annual appropriation of $20,000,000, an open-end appropriation with the sky the limit. The present appropriation of $2,000,000 to provide demonstrations and to train personnel for State and local health work is increased to $5,000,000.

In order to pave the way for the Public Health Service, under the coordinating guidance and control of the Social Security Board, to integrate the activities of all Federal and State agencies dealing with medical care, S. 1606 provides for cooperation and working agreements between the State health agency and any public agencies administering services related to public health services. The States are invited to pay State and local tax funds into the Federal Treasury for medical care and hospitalization services for the needy, for workmen's compensation cases, and for State and local governmental employees. Thus the way is opened for the Social Security Board to tap the fiscal resources of States and localities in order to swell the size of the Federal social insurance trust fund which would include, but not be limited to, the personal health services account.

One may question the fiscal and administrative wisdom of siphoning off into the Federal Treasury State and local funds intended for medical care of persons not included in the social insurance scheme, such as teachers, policemen, firemen, mothers and children, the needy, etc. This is clearly a device to do two things: (1) Augment the Federal social insurance trust fund and (2) bring under Federal rules and regulations all physicians serving the noninsured groups just mentioned. If these local public medical care activities are all brought into the Federal insurance scheme by the device of making payments to the Federal Government for specified medical services for those outside the insurance scheme, obviously the funds available locally for these activities will be reduced, for they will be put through the "Federal wringer" * * * and a certain amount of tribute will be squeezed out to pay the salaries of Federal administrators.

Senator Wagner in expanding the community health services adds a new medical care program to be financed from general revenues and administered by the Social Security Board. Seemingly, the Senator failed to learn his lesson when he vainly attempted in 1939 to give administrative jurisdiction of the Nation's medical care program to Isidore S. Falk in the Social Security Board. Now the Senator again proposes to deliver the sick poor of this country to the tender mercies of the Social Security Board which still has no health or medical staff and no administrative experience in local health or medical activities. If there are to be Federal grants to States to aid them in providing medical care for the needy, is not the United States Public Health Service the logical agency to administer the funds? We now have medical care programs being administered by the Public Health Service, the Children's Bureau, the Veterans' Bureau, and the Department of Agriculture. Is there any good reason for authorizing still another Federal agency, especially one now lacking an administrative staff of health and medical experts, to create a staff to pass on State plans for medical care and to supervise administration thereof?

Compulsory sickness insurance.—In the second part of S. 1606, Senator Wagner sets forth the provisions for sickness insurance medical benefits, the so-called prepaid personal health service benefits. They are much the same as under S. 1050. But there are some changes. Since this bill purports not to be an integral part of a sickness insurance scheme, there is no reference to the national social insurance trust fund which would be created in S. 1050. In the earlier Wagner-Murray-Dingell bill of May 24, 1945, the trust fund was set up as the Federal repository for all the pay-roll taxes to be collected by the Social Security Board, for all funds to be appropriated by Congress for benefits for insured persons and to cover deficits created by the operation of the insurance system, and for all funds paid by State and local governments for services for the needy, etc. In that trust fund, according to S. 1050, there was to be set up a personal health services account. The fund was to be managed by three trustees—the Secretary of the Treasury, the Secretary of Labor, and the Chairman of the Social Security Board. Although the health fund would comprise $4,000,000,000 or more a year, there was to be no health or medical representative on the Board of Trustees. For all practical purposes the Social Security Board, administrative agency for the major portion of the national social insurance scheme, would control the fund. While the present bill S. 1606 studiously avoids all mention of the national social insurance trust fund, the same questions should be raised now as in connection with the fiscal set-up in S. 1050. Why should the health fund not be separated entirely from the funds for the Social Security Board's cash maintenance programs? If the health funds are separated from social security cash benefit funds only to the extent of being separate entries on the Federal ledger for the insurance trust fund, would they not be in jeopardy if there were pressure on the social security funds in a period of widespread depression or in any other national emergency? The health funds should be in a completely separate account and should be managed by a Board of Trustees independent of those managing the social security (i. e., income-maintenance) funds. Since S. 1606 gives no guaranty of integrity and separateness for the health funds, it is reasonable to surmise that none is intended. Eventually, if both S. 1606 and a compulsory insurance tax measure were passed, health funds would be lost in the larger insurance or at best would be but feebly protected. Physicians, dentists, nurses, and hospitals would have no assurance that funds for their services would be protected. In Great Britain the capitation fees of physicians have been reduced when the Government was faced with other pressing demands for funds.

Senator Wagner in his remarks on the floor of the Senate made a number of claims designed to allay the fears of those who believe this legislation would lead to the socialization of medicine. He asked himself the question: "Does the prepaid medical care title of the bill provide for 'socialized medicine'?" His reply is: "No; if by the term 'socialized medicine' is meant medical care furnished by Government doctors free of charge." The Senator makes the statement that title II of S. 1606 will make "medical services more generally available than they are today, while retaining free choice of doctor for the patient and freedom on the doctor's part to work under the system or to remain out of it, as he prefers."

Senator Wagner surely must realize that when virtually the entire working population, including wives, is insured and when by one device or another the noninsured population is brought within the ambit of insurance practice, there will be practically no area left for private practice. Does he not know that this is the experience in Russia? While theoretically at the start, before the compulsory scheme becomes fully operative for the entire population, physicians may elect to enter or remain outside insurance practice, as the scheme spreads all physicians are compelled to participate if they wish to remain in medicine. The number of patients who are financially able to seek physicians on a private basis dwindles and the area of private practice of necessity shrinks to the vanishing point. Ultimately all physicians will be salaried servants of the state if the entire population is brought under a compulsory sickness insurance scheme. Administratively and financially there is no alternative. New Zealand a few years ago attempted to operate a Nation-wide medical care plan on a fee-for-service basis, for the most part. The system collapsed. Now there is talk either of abandoning the whole plan or of instituting straight state medicine by putting all physicians on a salary.

The nationalization of physicians under S. 1606 is inescapable. It is part of a plan carefully worked out by the International Labor Office to set up state socialism throughout the world. Control of medicine by the state is an entering wedge.

The International Labor Office in its report[1] summarizing world trends states:

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. The *next stop* to a *single national medical service* is a short one. * * *" [Italics mine.]

In the report on health insurance submitted to the Canadian House of Commons in 1943 is this sentence:

"During the early years of Hitler's regime, the government's medical program was looked upon by many as one of the greatest props of the totalitarian state."[2]

Dr. SHEARON. In 1945 the administration planned and hoped that the whole legislative proposal could be enacted at one time. That is S. 1050. I might say that the Reorganization Plan No. 3 of last year made some quite important changes in the basic social security law inasmuch as every place where you had had the Social Security Board doing something, it is now done by the Federal Security Agency. The implications of that are much more important than one sees right off the bat.

It might even look like a very unimportant change. I might call to your mind that in 1939 when the Federal Security Agency was formed that Agency at first was in the position of something like a holding corporation. In other words, it was not an operating agency. It had a small staff and was simply an over-all supervisory agency over the Social Security Board, the Public Health Service, the Office of Education, and a certain number of other minor units.

---

[1] International Labor Office, Montreal, Canada, 1942, pp. 50–51.

[2] Health Insurance, Report of the Advisory Committee on Health Insurance, 1943, Montreal, Canada, p. 108.

That was in '39, but when under the reorganization law last year the Social Security Board was abolished as a board and we had it changed to a one-man Commissioner for Social Security, the Federal Security Agency was changed into an operating agency and took over the functions of the Social Security Board.

Now that is a very important major change, and I think it was directed toward the idea of subsequently asking, as has been done, to have the Federal Security Agency then lifted to Cabinet status. It was a move on up. It means that the original Social Security Act in which you had the Chairman of the Social Security Board doing thus and so, you now have the Federal Security Administrator doing thus and so. That has some very important repercussions. At any rate the national social insurance system which would formerly have been under the Social Security Board, now is administratively under the Federal Security Agency. Among the other things, for instance, that agency instead of the Bureau of Internal Revenue would collect all the social security taxes or designate the collecting agency.

That also is a very important thing. I think when you consider the magnitude of the social security taxes that pour into the Federal Government, billions of dollars a year, you will realize that if you transfer that function from the Bureau of Internal Revenue to the Federal Security Agency you are giving a considerable amount of power.

Senator DONNELL. Doctor, you did not give the sentence reading, "A national social insurance trust fund would be created on the books of the Treasury of the United States." Did you intend to omit that?

Dr. SHEARON. No, I didn't. That is a very important thing also in giving you, shall we say, the picture of great power vested in a single agency, and centralized in the Federal Government. You would have set up this national social insurance system, you would have created a national social insurance trust fund on the books of the Treasury of the United States, and you would have the taxes collected by the United States agency——

Senator DONNELL. Is that trust fund the same thing that has been mentioned in the President's budget this year?

Dr. SHEARON. Yes. At the present time we have a number of separate trust funds. They are simply bookkeeping arrangements, and in the President's message he refers, for instance—not only refers but he includes in his table a health insurance fund. I don't think I have a copy of it.

Senator SMITH. It has been our custom when the Senate is in session not to continue without getting consent. I should like to ask my colleagues whether they want to adjourn at 12 o'clock until next Tuesday or whether you want to come back this afternoon. Senator Murray, what is your opinion?

I might say before I ask you that question, I am very much interested in certain features of the St. Lawrence Waterway debate that I don't want to miss personally, and I will have to leave for part of the time this afternoon in the event we have a session. So far as I am concerned, I would prefer to adjourn until next Tuesday. I understand we cannot meet Monday because of a number of conflicting engagements.

Senator MURRAY. It would be satisfactory to me if we adjourned until next Tuesday. I think we all have been very busy the last few days. I didn't have an opportunity to go over the statements.

Senator SMITH. I am just advised by Mr. Rodgers, the clerk of the committee, that there is another hearing scheduled for Monday and Tuesday here, so it will have to go over until next Wednesday.

Senator MURRAY. That will be satisfactory.

Senator DONNELL. That is satisfactory to me.

Senator SMITH. I will serve notice we will adjourn at 12 o'clock until next Wednesday morning at 10 o'clock, and you can continue now, Doctor, up until 12 o'clock.

Dr. SHEARON. The significance of S. 1320, therefore, does not come fully to view until one sees it in this comprehensive setting. Medical care insurance would be one part of the national social insurance system.

Legally, administratively, and financially it would be linked to all the other programs in that system. It would be closely related to the two cash benefits programs, one for temporary disability, the other for permanent disability.

I come back to that question you asked me, Senator Donnell, about the trust funds. I didn't quite finish. I was looking to see if I had a copy of the President's message in my bag. I will bring it next time, but he does there set up a health insurance trust fund in accordance with this legislation, S. 1320, as being pending legislation, and if it were enacted there would be such a trust fund, and the estimate is that there they would collect the first year $150,000,000 which would go into that trust fund and Congress would authorize an appropriation of $15,000,000 for administration the first year, getting the program set up.

At the present time we would undoubtedly have a series of such trust funds, but they would all be part of an over-all national social insurace trust fund and there would simply be different bookkeeping entries in the Treasury accounts, one for old age, and any other entries for any other trust fund brought into the total picture.

In deciding whether you think this type of legislation is desirable for the people of the United States it may help you to visualize how it would operate.

Let us suppose that Congress has enacted S. 1320 and the other bills to create a national social insurance system and that the Executive Branch of the Government is now ready to begin administration. New social security taxes would be imposed immediately for the purpose of building up reserves in the several trust accounts in the Federal Treasury.

These taxes would be modest at the start in order not to alarm the Congress or create too much popular resistance. Within a few years they would rise probably to 6 percent on employees and 6 percent on employers on the first $4,800 of income.

At the present time the social security tax has been frozen at 1 percent on the first $3,000. In one of the earlier Wagner-Murray-Dingell bills it was proposed to raise the tax to 6 percent on the first $3,600 and now at this recent meeting of the advisory council of the Finance Committee in December, Commissioner Altmeyer proposed that the tax be imposed on the first $4,800 of income. I should like very much to include the statement which Commissioner Altmeyer gave, exhibit B, at that time in which you will see the breadth of the proposal that he is making for expanding the social security program to come before the Finance Committee. You might not have very much information about it. You wouldn't be seeing the total picture coming through a number of fronts in different committees.

(Subsequently Robert M. Ball, staff director, Advisory Council on Social Security, submitted Mr. Altmeyer's statement as follows:)

STATEMENT BEFORE THE ADVISORY COUNCIL ON SOCIAL SECURITY—SENATE FINANCE COMMITTEE BY A. J. ALTMEYER, COMMISSIONR FOR SOCIAL SECURITY, DECEMBER 4, 1947

THE MEANING OF SOCIAL SECURITY

Social security in the most inclusive sense of the term includes all of the things necessary to enable the individual citizens of a country to lead a personally satisfying and socially useful life. In this large sense social security would certainly include decent housing, education, and health as well as the elimination of destitution.

There is considerable danger that giving the term "social security" such an inclusive meaning will destroy its usefulness as a term to describe a specific program of action. Therefore, I shall use the term in a more restricted sense as applicable to a specific program designed to eliminate want by preventing loss of income and affording protection against large and unforeseen economic hazards such as the cost of medical care.

I should like to point out that even though we achieve the goal of full employment and full production it is still necessary in a system of private enterprise such as ours to have a program designed to eliminate want, because the working people of this country will still be confronted with the great economic hazards of sickness, physical disability, want, old age and death as well as intermittent unemployment. All of these great hazards mean interruption of income to the individual family and still spell want in a land of plenty.

I mention intermittent unemployment as a continuing major cause of loss of income because, under a system of free enterprise, we must encourage invention, improvement, variety, and continual adaptation to changing ideas and circumstances. This must mean that, as the processes of production and distribution change, individuals will be forced out of one employment and be obliged to seek another. This is the price, if it can be called a price, that we pay for maximum production, free enterprise and free labor.

Of course to the extent that we fail to achieve full employment and full production, a system of social security designed to eliminate want is all the more necessary. Nor should we overlook the fact that a system designated to eliminate want also does actually make a great contribution to the maintenance of full production and full employment by helping maintain mass purchasing power, upon which mass production must depend.

In presenting to you a specific social security program it will not be necessary to propose strange and new methods. We have a world history and world experience upon which to base our planning and our action. Indeed we already have in our own Social Security Act the fundamental elements of a program of social security designed to eliminate want. Therefore, in my judgment it is only necessary for us to extend, expand and improve upon our present Social Security Act in the light of the experience and think that has been developed since that act was passed in 1935.

Since the security of the large majority of people is dependent upon their earnings, the focal point of our efforts should be to provide reasonable protection against interruption of income due to sickness, accidents, old age, death, and unemployment. In other words, we should strive to devise a system which will spread income over periods of non-earning as well as over periods of earnings. This can be accomplished to a large extent by a system of social insurance under which benefits are paid to compensate for a reasonable proportion of the wage loss sustained. The cost of such benefits should be financed out of contributions made by the workers of this country and by their employers, supplemented ultimately with some contribution from the Government, representing the entire community.

THE RELATIONSHIP OF SOCIAL INSURANCE AND PUBLIC ASSISTANCE

However, even a comprehensive contributory social insurance system cannot provide complete protection under all conceivable circumstances. Certainly an insurance system cannot insure against hazards that have occurred prior to the establishment of the system. Therefore, there is also need for a basic and comprehensive system of public assistance to meet the needs of individuals and their families which cannot be met out of their own resources.

The late Oswald Stein, the world's greatest authority on social security at the time of his tragic death, best characterized the true nature of these two systems. He said, in a report of the International Labour Office: "Social assistance is a progression from poor relief in the direction of social insurance, while social insurance is a progression from private insurance in the direction of social assistance." This statement suggests that there are areas of similarity and areas of distinction in the two programs.

Assistance and insurance are alike in that they seek to provide a minimum degree of economic security. In so doing both strive to remove uncertain and subjective tests of eligibility and to create certainty and objectivity. Both have endeavored to obtain improved methods of financing and thus to create confidence that benefits will be available when they are needed. And both are continuously providing more nearly adequate payments to those who qualify for them.

The methods which each program employs complement one another and are both essential in order that protection may be well-rounded and able to meet all foreseeable contingencies that are common to mankind. At the moment in this country public assistance is playing the dominant role, since it must care for those cases where the wage earner was old or died before our social insurance program got under way. As social insurance develops and spreads its protection more widely, it is hoped that it will eventually—perhaps before another generation has passed—become the predominant program and will take care of the bulk of the problem, providing benefits for the great mass of the population . Such a development would not mean, however, that a system of social security can ever dispense with public assistance. Assistance would always be needed as a residual program for those who are not protected by social insurance because it is not feasible to cover them or because they become disqualified from social insurance benefits. Assistance would also be required to supplement social insurance benefits when they prove inadequate to meet special needs of individuals.

The two programs, similar in purpose but different in provisions which enable them to meet their respective obligations, show certain rather significant contrasts as they are constituted today. To illustrate, an applicant for social-insurance benefits may qualify without regard to his other resources, whereas the applicant for public assistance will have his other resources taken into account. Associated with this difference is another: Insurance benefits are provided on the presumption that most people, when they meet certain defined risks, will be in need of cash income, although it may happen that an individual beneficiary may not be. The applicant for public assistance, on the other hand, must show actual need if he is to qualify for a grant.

NEEDED IMPROVEMENTS IN SOCIAL INSURANCE

This Advisory Council will be confronted with the necessity of determining how far these twin programs have advanced us toward the goal of a minimum level of well-being for everybody. Without undertaking to prejudge your conclusions I think you will find that we are still a considerable distance from our goal. So far as social insurance is concerned, both of the two existing programs of unemployment insurance and old-age and survivors insurance fail to provide protection to millions of workers whom it would be perfectly feasible to protect. They do not cover agricultural workers, domestic workers, or workers employed by nonprofit organizations. In the case of unemployment insurance, workers employed in small establishments are also excluded from protection. The benefits payable to workers who are insured are far from adequate to meet a reasonable proportion of the wage loss.

Aside from the limited coverage of workers and inadequate benefits provided under our present social-insurance systems, the greatest lack is failure to provide any protection whatsoever against nonindustrial ill health and permanent disability. Not only is no protection provided against the wage loss involved but there is no provision for spreading the cost of adequate medical care. In determining how to provide adequate medical care for the people of this country it is essential that the distinction between socialized medicine and health insurance be kept in mind. Socialized medicine implies medical services provided by physicians in the employ of the Government; health insurance implies a system whereby medical service is provided by private practitioners who are reimbursed from a special insurance fund for the services they render. Every State but one is already operating a system of compulsory health insurance applicable to accidents and disease arising out of occupation—that is, workmen's compensation.

NEEDED IMPROVEMENTS IN PUBLIC ASSISTANCE

Of course, if we strengthened our social-insurance system by extending coverage, providing more adequate benefits for the risks already covered, and providing protection against the cost of medical care and wage loss due to ill health, we would greatly lighten the load that public assistance must carry. But even so, there are many changes that would need to be made in our system of public assistance if it is to serve as an effective second line of defense against want. At present the Federal Government is making grants to the States to assist the States in paying the cost of cash assistance to the needy aged, the needy blind, and dependent children. However, no Federal grants are available to cover any part of the cost of cash assistance to needy persons not falling within these three categories, and no Federal grants are available to the States to provide necessary welfare services except to a limited extent in the case of children.

In examining the operation of the various State programs one is immediately struck by the fact that there is great inequity in the treatment of persons in similar circumstances not only as between different States but as between different sections in the same State. What is even worse is the fact that we do not have today a system of public assistance that provides the funds necessary to meet the acknowledged minimum needs of persons who have been investigated and found to be eligible. From the data available it would appear that about one-third of the families now receiving public assistance in the United States are getting less than the amount certified as necessary by the workers in the State agencies administering the program.

Federal grants related to the economic capacity of the States would do much to enable the States to meet the full needs of eligible individuals as determined by the State. However, unless within the State funds are made available to every locality in accordance wits its needs gross inequities of treatment would still exist. Federal grants to the States to assist in meeting the needs of needy persons not falling within the present categories are also necessary since there is great disparity between cash assistance granted persons falling within the three categories mentioned above and the cash assistance granted needy persons not falling within those categeries.

IMPROVEMENTS IN THE OLD-AGE AND SURVIVORS INSURANCE SYSTEM

I understand that this Advisory Council desires first to consider the ways and means of improving the present Federal old-age and survivors insurance system. Therefore, I shall devote the rest of my time to a discussion of this particular phase of social insurance which deals with what might be called the long-term economic risks to which the workers and their families of this country are exposed; namely, death, old age, and permanent and total disability.

In considering any type of social insurance I believe that it is necessary to keep in mind two fundamental principles: The first is that only a minimum degree of protection can be afforded; second, that this minimum degree of protection is a general minimum which does not always cover the individual needs of each worker and his family. In other words, I believe that social insurance should be looked upon as providing a minimum degree of protection upon which the worker himself through his individual efforts may build more surely and effectively a higher standard of living for himself and his family. We should assume that in a country such as this workers by and large will have an opportunity to accumulate some savings, take out some private insurance, and have an opportunity to own their own homes. The success of a system of social insurance should be measured by whether such a system together with private savings, insurance, and home ownership results in most of the people of this country being able to maintain themselves in decency and comfort. This test might be called the test of social adequacy. But in addition I believe that any social-insurance program functioning within a system of free enterprise must also take into account individual equities and incentives. Therefore, while I believe that the low-wage earner and the worker who is already advanced in age should be compensated for a larger proportion of the wage loss sustained, I also believe that the benefits paid to younger wage earners receiving higher wages should take into account the length of time that they have contributed and the larger wage loss they sustain when they cease employment.

As the Advisory Council knows, the Federal old-age and survivors insurance program is the only part of the Social Security Act which is administered wholly by the Federal Government. Employers and employees have each been making contributions of 1 percent of taxable wages since January 1, 1937. Under the original provisions of the Social Security Act, monthly benefits would not have been payable until January 1, 1942; the 1939 amendments, however, advanced that date to January 1, 1940. The 1939 changes also resulted in the payment of more adequate benefits during the early years of the systems' operation. Above all, the amendments added dependents' benefits and survivor's benefits so that now, in addition to the payment of old-age benefits to workers themselves, monthly benefits are also payable to the aged wife and young children of a living beneficiary and to the widow, children, and, in some cases, the dependent parents of an insured worker who dies. Just as contributions are paid on the basis of wages received, so these benefits are paid on the basis of the past wages of the insured worker and thus compensate for a portion of the wage loss sustained by his retirement or death.

This Federal old-age and survivors insurance system constitutes the largest permanent insurance system in the world. Therefore, unprecedented problems have been encountered in putting it into effect. However, all of these administrative problems have been solved. The total cost of administration at the present time is less than 3 percent of contributions collected and less than 10 percent of benefit payments. We confidently expect that as benefit rolls increase the cost of administration will decline to less than 5 percent of benefit payments.

At the present time there are 1,950,000 aged persons, widows, and orphans receiving monthly benefits. Over 88,000,000 individual worker accounts have been established. The cost of maintaining these wage records is less than 12 cents per account.

There can no longer be any question as to the effectiveness and practicability of this Federal old-age and survivors insurance system. However, the years that have passed have indicated various ways and means in which it could be improved and also demonstrated that its benefits could be extended to cover all gainfully employed persons, including the self-employed.

LIBERALIZATION OF BENEFITS

The level of benefits provided in the existing law was enacted in 1939. Since 1939, the cost of living has increased by at least 60 to 65 percent. Average wages of individuals credited under the insurance system have increased by 55 percent (from $881 in 1939 to $1,370 in 1946). Various studies have shown that the present benefits were inadequate even before these increases in cost of living and wages.

Among the changes which I recommend for consideration is a modification of the benefit formula so as to represent a larger proportion of the wage loss sustained by claimants, particularly those with low earnings.

I believe that the wage base for both contributions and benefit-computation purposes should be the first $4,800 in taxable earnings in a year, rather than the first $3,000. Such a change would recognize the general increase in wage levels and would result in benefits representing a somewhat larger proportion of the wage loss actually sustained by families in middle- and upper-income brackets.

Certain items of income such as tips and dismissal wages which are now not considered "wages" under the definition in the act, should be included as wages, so that the base for benefits would represent the worker's actual earnings from employment.

I also believe that certain changes should be made in the provisions governing minimum and maximum benefit amounts. A reasonable standard of adequacy would seem to require a minimum benefit of $20 for an eligible worker rather than the present $10 a month even though most workers would have earnings that would qualify them or their survivors for more than the minimum amount.

At present, the maximum total amount payable to the worker and his dependents is $85 a month, twice the primary benefit amount, or 80 percent of the average monthly wage of the insured worker, whichever is least.

I believe that the $85 maximum limit should be raised to $120 and that the second limitation of twice the primary benefit (which is the amount payable to a worker without dependents) should be eliminated. The chief effect of these changes would be to provide more adequate benefits in the case of a widow with several children.

It has been well established that women retire from gainful employment at an earlier age than men. It is also well known that wives are ordinarily younger than their husbands. Of the married men who reach age 65 each year, less than 20 percent have wives who also have reached age 65. The age requirement is lower for women than for men in many of the social insurance programs of foreign countries and also in many of the retirement systems established in this country by various State and local governments and private concerns. I therefore recommend that consideration be given to reducing the age at which women may qualify for a retirement benefit or a wife's benefits from 65 years to 60 years.

The law now provides a small lump-sum payment if there are no surviving dependents entitled to monthly benefits at the time of the worker's death. I recommend that this small lump sum be paid whether or not there are surviving dependents entitled to monthly benefits, since the need for it is as great in either case.

Under the existing law benefits are suspended for any month in which the beneficiary earns more than $14.99 in covered employment. The amount of permissible earnings could well be increased without fear that beneficiaries will encroach on the job opportunities of regular, full-time workers. I believe that earnings of $40 a month should be permitted without suspension of benefits and that beginning at age 70, irrespective of whether the individual was employed or not and irrespective of his income or earnings, benefits should be paid.

BENEFITS FOR PERMANENT TOTAL DISABILITY

Disability is among the important causes of insecurity. On an average day of the year, about 3½ million persons are suffering from disabilities which have already lasted six months or more. About 1.6 million of these persons are in the ages between 15 and 65 and, but for their disability, would have been engaged in productive work. Disability is one of the major causes of dependency. The extent to which dependency is due to invalidity is evidenced also by State reports to the Social Security Administration, which show that one-fourth of the children granted aid under the assistance program are the children of distabled fathers. Various State and local studies have found that even larger proportions of recipients were receiving general relief primarily because of dependency resulting from the disability of the breadwinner. The cost of dependency falls largely on the public purse.

These and other studies leave no doubt that a comprehensive program of social security must protect families and individuals against loss of earning capacity by reason of disability. It is significant that every other country in the world which has an old-age retirement program provides for retirement necessitated by chronic or permanent disability.

On the basis of extended study and of the actual experience in the payment of monthly benefits since January 1, 1940, I strongly recommend the inclusion of permanent total disability insurance in the Federal system.

EXTENSION OF COVERAGE

If the old-age and survivors' insurance system is improved in accordance with the foregoing suggestions it becomes increasingly desirable and necessary that the coverage of the system be extended as widely as possible, since the whole population of this country is subject to these hazards in varying degrees.

The present Federal old-age and survivors' insurance program covers, with certain important exceptions, employers of one or more employees. Despite these exceptions, social security account cards have already been issued under this program to more than 88 million persons, of whom 81 million already have had some wage credits posted to their accounts because of work in insured employment. It is apparent from these figures that a large proportion of the gainfully occupied population already has some measure of protection against old age and death. However, it is also apparent that many persons pass back and forth between insured employment and uninsured employment. In 1946 while only 33 million individuals were engaged in insured employment at any one time, over 49.5 million individuals worked in insured employment during the course of the year.

Since the amount of a benefit depends to a considerable extent upon the length of time an individual actually worked in insured employment and the amount of his earnings in such employment, persons who pass in and out of insured employment get lower benefits than they would have, on the basis of the same amount of total earnings, if all their work had been insured employment. Some of them may never acquire insured status or may lose it before benefits become payable and so may receive no returns at all on their contributions. Persons who always work in uninsured employment are unable, of course, to develop any benefit rights whatsoever.

The main groups now excluded from old-age and survivors insurance and unemployment insurance are agricultural laborers, domestic servants, employees of nonprofit organizations, public employees (Federal, State, and local), and self-employed persons, including small-business men and farmers.

AGRICULTURAL LABOR AND DOMESTIC SERVICE

About 3.5 million agricultural workers and over 2½ million domestic servants during the course of a year are excluded from old-age and survivors insurance. These two are the largest and most necessitous groups of the workers now unprotected. A principal reason for exclusion of these two groups was the administrative difficulty due to the large number of small employers involved and the fact that most of these employers do not keep books and would find difficulty in making reports. On the basis of studies made during the past 10 years, I believe that it is administratively feasible to extend coverage to these groups through the use of a stamp-book system. Under such a system each employee would receive a stamp book in which stamps would be placed by his employer to evidence contributions made by the employer and the worker. In rural areas the employer could purchase these stamps from the mail carrier, and in urban areas they could be purchased at post offices. A stamp plan could be used also by smaller industrial and commercial establishments which found it more convenient.

EMPLOYMENT BY NONPROFIT ORGANIZATION

I also recommend the inclusion of service performed for religious, educational, charitable, and similar nonprofit organizations. No administrative difficulties would be involved in extending coverage to these groups.

PUBLIC EMPLOYMENT

I believe that it would be highly desirable to extend the basic protection of the social insurance system to all public employees—Federal, State, and local.

Special retirement systems now cover approximately three-fifths of all public employees. It would be possible to revise these special retirement systems so that their benefits would be superimposed on those payable under the basic social insurance system. Such a revision would, of course, have to be made in such a way as to increase, not reduce, the total protection afforded to public employees. I recommend that in the case of Federal employees, if agreement cannot be reached as to the necessary adjustments in the existing Federal retirement systems, at least the Federal employees who are not protected by an existing retirement system be covered under the basic old-age insurance system.

In the case of State and local employees, I see no major administrative difficulties in permitting the governmental units to be covered voluntarily, provided there are proper safeguards to protect the social insurance system against adverse selection.

RAILROAD RETIREMENT

At present employment within the railroad industry and that outside the industry are covered by two different social-insurance systems. These are coordinated on only a limited basis. Under the 1946 amendments to the Railroad Retirement Act eligibility for and amounts of benefits payable to survivors are based on combined earnings under both systems. However, no coordination is provided with respect to retirement benefits. Consequently, workers who move between railroad employment and employment covered under old-age and survivors insurance may lose all retirement protection under old-age and survivors insurance and, because of the time spent under old-age and survivors insurance, may also suffer a reduction in the benefits payable under the railroad system. On the other hand, depending on when the shift in employment took place, dual benefits may be paid upon retirement. The only completely adequate remedy is the extension of old-age and survivors insurance to railroad employment. As in the case of the coordination of old-age and survivors insurance and systems covering Government workers, those covered by the Railroad Act need not suffer any loss or diminution of benefit rights under such coordination.

THE SELF-EMPLOYED

I recommend that the protection of the system be extended to self-employed persons, such as small businessmen and farm operators, whose need for such protection is as great as that of persons in the employ of others. The self-employed could report their earnings from self-employment as a part of their income-tax return. There is, of course, the special problem of determining how much income is due to self-employment as distinguished from return on investment. However, a reasonable approximation of this can be made from items already in the income-tax return. Therefore, there are no insuperable administrative problems which would prevent extension of coverage to the self-employed.

DISADVANTAGES SUFFERED BY NEWLY INSURED GROUPS

If these recommendations relative to broad extension of coverage of the old-age and survivors insurance system are enacted into law it will be necessary to adjust the eligibility requirements and the method for determining the average monthly wage upon which benefits are based so that the newly insured groups will not be unduly disadvantaged because of their late entrance into the system. As the law now stands a person who has not been working in insured employment for roughly one-half of the time since the law went into effect on January 1, 1937 (or one-half the time since the date he became 21 years of age, if that date is later) is not fully insured and, therefore, not entitled to an old-age retirement benefit. Therefore, it would take a farmer, who had never worked in insured employment previously, 10 years before he could qualify for an old-age retirement benefit. Even at the end of 10 years the average monthly wage would be one-half of the average wage he had earned during that time since his wages during that time would have to be averaged over the whole period since January 1, 1937, namely 20 years. I am prepared to submit various alternative proposals which would help correct both of the foregoing types of inequities.

PROTECTION OF VETERANS

If the old-age and survivors insurance program were extended to include all Federal employment, both in the civilian and military establishments, soldiers and civilian employees would have the basic protection of this system at all times. It would also be possible to provide additional special protection on a consistent and certain basis. Any other approach to the problem of providing protection to soldiers and civilian employees of the Federal Government inevitably results in some gaps, overlaps, anomalies, and administrative difficulties.

With respect to veterans of World War II, the lapse of time since they entered military service and the fact that many millions have already left military service creates problems which make it impossible to arrive at an ideal solution.

In 1946 Congress provided what was in effect free term-insurance protection to veterans in the event of the death of a veteran during the period of 3 years immediately following separation from active military or naval service. This period of time enables veterans to acquire at least currently insured status if they enter insured employment for as much as one-half of that period. However, for those veterans who do not enter insured employment this insurance protection ceases upon the expiration of the 3-year period. Even those veterans who enter insured employment suffer some reduction in their benefits because military or naval service is not insured employment. Thus, their average wage upon which benefits are based is less and they do not receive the 1-percent increment which is provided for each year that a person is in insured employment.

COSTS

It was estimated in 1939 at the time the law was amended that the most probable range in the average long-run cost of the benefits to be provided would be 4 to 7 percent of covered pay rolls. Of course, actuarial estimates must be presented within a wide range, since nobody can predict accurately future economic conditions, mortality rates, population growth, retirement rates, and many other such factors upon which actuarial estimates must be based.

One fact is clear, however: The present old-age and survivors insurance law provides for the payment of primary benefits of 40 percent of the first $50 in average monthly wages and 10 percent of the remaining amount up to $200 additional. As an individual's wages increase, he always receives a larger benefit, but this benefit represents a smaller proportion of his wages as wages increase.

For instance, the individual receiving average wages of $100 per month receives basic old-age insurance benefit of $25 per month, or 25 percent; the $250-per-month individual receives $40 per month, which represents 16 percent. Thus, as the average wage of insured persons increases, the relative costs of the present benefits measured as a percentage of pay roll will decrease. At the present time the average wage of persons contributing to the insurance system is substantially higher than the average wages assumed in making the actuarial cost estimates in 1939. This single factor has resulted in a great reduction in the relative costs of the insurance plan. In calculating the costs of the proposals I have presented, it must be borne in mind that extension of coverage would result in including all the wages of many individuals who are already under the insurance system part of the time. This would increase their taxable wages and reduce the relative cost of the insurance plan, as already explained.

Therefore, while it might be necessary eventually to increase somewhat the income of the system to meet the cost of the various additional benefits recommended, the schedule of rates payable by employers and employees, as reduced by Congress this year, would be sufficient to cover current costs of an expanded program for the next 10 years or more. I believe that when the present schedule of rates fails to cover current disbursements the Government should begin to contribute.

I should like to submit to the Advisory Council brief summaries of specific recommendations covering the following subject, either at this time or later, as the Advisory Council may desire: (1) Extension of old-age and survivors insurance to all gainful employment; (2) coverage of the self-employed under old-age and survivors insurance; (3) improvement of existing old-age and survivors insurance benefits; (4) permanent disability benefits under old-age and survivors insurance; (5) financing of expanded old-age and survivors and permanent disability insurance program.

1. *Extension of old-age and survivors insurance to all gainful employment*

Desirability.—Many of those who are not now covered under old-age and survivors' insurance do not have any protection against the risks of old age, death, and disability. Many of those who shift between employment covered under old-age and survivors' insurance and noncovered employment do not acquire insured status under old-age and survivors' insurance, and derive no protection from the contributions they have made. An extension of coverage to all gainful employment (including self-employment) would assure the basic protection of the program to all members of the labor force, regardless of type of work or changes in jobs.

Agricultural and domestic employees.—Workable solutions have been developed for the administrative problems of covering agricultural and domestic employees. Reporting of wages and the payment of contributions could be accomplished either by a stamp method or through employer reports. The problem of evaluating noncash wages, such as meals and lodging, could largely be met by use of a schedule of presumed values. It would be advisable to exclude exchange labor and unpaid family labor.

Employees of nonprofit institutions.—No administrative problems would be involved in covering nonprofit employees. If religious organizations desired, clergymen and members of religious orders might continue to be excluded from coverage. The legislation might also declare that coverage of nonprofit employment is not intended to violate the traditional tax-exempt status of nonprofit organizations.

Federal civilian employees.—An extension of coverage to civilian employees of the Federal Government, coupled with appropriate adjustment in the civil service retirement system, would be of substantial value to most workers. Workers who shift between Federal employment and employment covered under old-age and survivors' insurance would have continuity of coverage, while career employees of the Federal Government would gain the valuable survivorship protection provided under old-age and survivors insurance. The rights of annuitants and employees under the civil service retirement system would, of course, be preserved, and the separate administration and financing of that system would be retained.

Employees of State and local governments.—Constitutional difficulties in the levy of a tax against State governments could be avoided by authorizing the Federal Security Administrator to enter into voluntary agreements with States for the coverage of their employees. Local governmental units could participate in the State agreements. Compulsory coverage might be provided for some groups of proprietary employees.

Railroad workers.—While the survivors' benefits of the railroad retirement program are coordinated with those of old-age and survivors' insurance, the retirement benefits of the two programs are separate. If old-age and survivors' insurance were extended to railroad employment, workers who shift between old-age and survivors insurance and railroad employment would have continuity of retirement coverage. As in the case of governmental employees, no loss to any worker need be involved.

Members of the armed forces.—An extension of coverage to future service in the armed forces would assure continuity of coverage for individuals who spend only part of their working lifetime in military service. The survivorship protection provided career servicemen would be especially valuable to them after they leave military service. The special survivorship protection under old-age and survivors' insurance now provided World War II veterans would seem adequate in the event of a general extension of coverage in the fairly near future together with modifications in the average monthly wage and insured status provisions of the program to remove handicaps because of prior periods of noncoverage.

Self-employed persons.—A separate statement describes a method for providing old-age and survivors' insurance protection for the self-employed.

Estimated employment covered by old-age and survivors' insurance, and employment in selected noncovered industries, years ended June 30, 1946, and June 30, 1947

[In millions]

Type of employment	Year ended June 30	
	1946	1947
Employment in an average week:		
Civilian labor force	54.8	59.3
Unemployed	2.0	2.2
Employed, total	52.8	57.1
Covered by old-age and survivors' insurance	29.6	33.0
Not covered by old-age and survivors' insurance	23.2	24.0
Agriculture	8.3	8.2
Hired workers	1.6	1.5
Farm operators	4.7	4.9
Employment in an average week—Continued.		
Agriculture—Continued		
Unpaid family workers	2.0	1.8
Nonagricultural self-employed	5.0	6.0
Domestic service	1.6	1.7
Government	5.3	5.2
Federal	2.3	1.9
State and local	3.0	3.3
Railroad	1.7	1.6
Nonprofit and other	1.3	1.3

2. *Coverage of the self-employed under an expanded old-age, survivors, and permanent disability insurance program*

Present status.—The majority of self-employed persons are just as much in need of old-age and survivors insurance protection as are wage earners. A number of social insurance programs in foreign countries now cover the self-employed. Many self-employed persons now pay contributions on behalf of their employees covered under the program and so are very conscious of their own exclusion. The owner of a business large enough to be incorporated acquires protection as an officer of the corporation, but the owner of a small unincorporated concern has no similar advantage. Moreover, many self-employed persons work at times as wage earners but fail to build up and maintain an insured status because their income from self-employment is not credited toward such status. Experience gained in the administration of the present law and in the income-tax law has made it possible to develop adequate methods of meeting the problems involved in coverage of the self-employed.

Reporting.—Contributions and benefits would be based on income from self-employed activity. For both the self-employed and the Government, the simplest way of reporting such income is as part of the income-tax return. The integrated returns would be for a calendar year and would be due on March 15 of the following year, as at present. Social-security reporting would be required only from persons with annual gross income of $500 or more (exclusive of income in kind for home use) and contributions required only from those whose "net income from self-employment," as defined below, is $200 or more. Consistent with the provisions for employees, the maximum annual net income from self-employment on which contributions would be payable would be $4,800 less the amount of any covered wages received during that year.

Contribution rate.—To avoid undue burdens upon the low-income self-employed, the contribution rate on income from self-employment should be only the employee rate on the first $500 of annual net income from self-employment and the combined employer-employee rate on all such income in excess of $500 up to the maximum.

Definition of net income from self-employment.—Net income from self-employment could be determined on the basis of two figures already included in the income-tax return, namely: income from business or profession (schedule C), and income from partnerships (schedule E).

Retirement test.—It would be presumed for an individual between the ages of 65 to 70 that if the individual's annual income from self-employment is less than $480, the individual is retired. If his income exceeds this amount, his benefits would be withheld only if there has been substantial activity directed toward the production of such income. In such case, 1 month's benefit would be withheld for each $40 of income in excess of $480 with a maximum of 12 months' benefits withheld on the basis of any 1 year's self-employment income. If the individual's income is not the result of substantial activity on his part, he would continue to receive his benefits without regard to the amount of his income from self-employment. Beginning at age 70, irrespective of whether the individual was employed or not or the amount of his income or earnings, benefits could be paid.

Illustrative form

For possible use in collecting Social Security Tax on income from self-employment in connection with the individual income tax. This form would be a perforated attachment to the Individual Income Tax Return Form 1040.

Form 1040 S. S.

SCHEDULE OF SOCIAL SECURITY TAX ON INCOME FROM SELF-EMPLOYMENT

Social security account number ----------
Home address ----------
Business address ----------
Nature of business ----------
1. Enter net profit from business or profession, item 22, schedule C ---------- ----------
2. Enter income from partnerships, syndicates, etc., from schedule E ---------- ----------
3. Net total of lines 1 and 2 ---------- ----------
4. Enter total wages received by you as an employee on which social-security tax has been paid ---------- ----------
5. Subtract item 4 from $4,800 and enter difference ---------- ----------
6. Enter line 3 or line 5 whichever is smaller. (This is your income from self-employment on which social-security tax is due) ---------- ----------
7. If line 6 is $500 or less, enter 1 percent of line 6, if it is more than $500 enter $5 ---------- ----------
8. If line 6 is over $500 enter 2 percent of amount in line 6 in excess of $500 ---------- ----------
9. Total of lines 7 and 8. This is your social-security tax ---------- ----------

NOTE.—This form uses a contribution base which includes income from business or profession and income from partnerships, syndicates, joint ventures, etc. The contribution base does not include annuities, pensions, dividends, interest, capital gains and losses, rental from real estate, royalties, and income from estates and trusts.

3. *Improvement of existing old-age and survivors' insurance benefits*

More adequate benefits.—The benefit scale established in 1939 provided a relatively small replacement of wages for most beneficiaries, even in terms of the wage and price levels of that period. Since then the benefits have become increasingly inadequate, as prices and wage levels have risen some 60 percent or more. The following changes in the benefit provisions are suggested to adapt the benefits to changed conditions:

(*a*) *Benefit formula.*—The benefit formula should be revised to provide a replacement of wages, in terms of present levels, at least as large as was provided in 1939 by the present formula. One formula which would accomplish the result for most workers would be one which replaced 40 percent of the first $100 (instead of $50) of average monthly wage and 10 percent of the next $300 (instead of $200).

Illustrative benefits under present law and proposed revision

Average monthly wage	Present law			Proposed revision		
	Basic benefit	10 years' coverage	20 years' coverage	Basic benefit	10 years' coverage	20 years' coverage
$50	$20	$22.00	$24	$20	$22.00	$24
$100	25	27.50	30	40	44.00	48
$150	30	33.00	36	45	49.50	54
$200	35	38.50	42	50	55.00	60
$250	40	44.00	48	55	60.50	66
$300	40	44.00	48	60	66.00	72
$400	40	44.00	48	70	77.00	84

(*b*) *Minimum benefit.*—If the change suggested above is made in the benefit formula and the average monthly wage is redefined as proposed below, the amounts payable to most individuals would be no less than $20. If the minimum primary benefit were set by law at $20 (instead of the present $10), this would assure a man and his wife a minimum combined benfit of $30.

(*c*) *Wage base.*—At present, only the first $3,000 of wages in a year is counted for benefit purposes. If this amount were raised to $4,800, it would now permit about 96 percent of covered workers to have all their wages counted for benefits, as compared to the 97 percent who had all their wages counted in 1939 under the $3,000 wage base.

(*d*) *Maximum benefit.*—The present law limits benefits to $85 per month, twice the primary benefit amount, or 80 percent of the average monthly wage of the employee, whichever is least. A higher maximum dollar amount, such as $120, would reflect the increase to $4,800 in the maximum annual earnings credited and would recognize the desirability of providing a relatively wide range of benefits under a program of contributory insurance. Omission of the requirement that the family total must not exceed twice the primary benefit amount would provide more adequate benefits when a worker is survived by a large family.

(*e*) *Average monthly rate.*—Under present law, benefits are based on total wages averaged over all months since 1936 (including months of little or even no earnings). Lack of wages in insured employment in any period reduces the average to an excessive degree when, as in the early years of the program, the period of coverage is short. To avoid this, the average wage could be determined by relating it only to those periods when the worker's earnings exceeded a certain amount, that is, by excluding certain periods of little or no earnings. In order to afford some variation in the amount of the benefit in relation to the length of time a person made contributions, the benefits might continue to be increased by 1 percent for each year of coverage, as is now the case, and reduced by 2 percent for each year the worker was out of covered employment.

(*f*) *Age of eligibility.*—The age for women might be redued to 60. Since wives are, on the average, about 5 years younger than their husbands, this change would in most cases permit the payment of supplementary benefits to the wife at the time the wage earner retires. Women wage earners and aged widows should be eligible at the same age as wives.

Eligibility.—To be fully insured, a worker must have been paid wages of at least $50 in (*a*) half the calendar quarters elapsed since 1936 or since age 21, or (*b*) 40 calendar quarters. This requirement would be difficult for newly covered workers to meet. Thus, it would take a farmer who had never worked in insured employment previously 10 years before he could qualify for an old-age retirement benefit. To make it easier, a person might also be deemed to be insured if he had covered wages of $200 in at least 5 of the 10 years before retirement or death.

Retirement test.—Benefits under the existing law are not paid for any month in which a person earns at least $15. In view of increased wage levels, a person between age 65–70 whose earnings did not exceed $40 could be considered as not engaged in regular employment and therefore in need of his benefit payments. Beginning at age 70, benefits could be paid irrespective of whether the individual was employed or not.

4. Permanent disability benefits under old-age and survivors insurance

Need for disability protection.—The loss of income suffered by a family when the breadwinner is stricken with a serious and long-lasting disability is fully as great as in cases of old age or death. Prolonged incapacity to work, whether due to accident, extended illness, or chronic disease, is a risk against which most workers and their families find it difficult to budget on an individual basis, or to secure protection through existing insurance or other benefit systems. On any one day about 1.6 million workers are suffering from major disabilities that have lasted 6 months or longer.

Extended disability is a major cause of destitution because the incidence of total disability is individually unpredictable, the wage loss suffered is frequently complete, and added medical expenses may make the burden of disablement heavier upon the family than that caused by old age or death. The fact that the incidence of permanent disability is reasonably predictable in the aggregate—although not individually—makes it an insurable risk and one which, like old age and death, can be effectively met through contributory social insurance.

Administrative feasibility.—The administrative feasibility of providing cash insurance benefits in such cases is reflected by the disability-benefit provisions incorporated in the old-age insurance system of every foreign country. In this country many plans, both public and private, contain disability provisions. Furthermore, there has been extensive administrative experience in the adjudication of disability under the Federal and State workmen's compensation programs, the veterans' programs, Federal and State civil-service retirement and disability programs, and the railroad retirement program. The existing facilities of the Bureau of Old-Age and Survivors Insurance, including the wage records and the field organization, would be available for the administration of disability benefits. Policing of the program would be aided by the regular wage reports received from employers on disabled persons if employed.

Scope of "permanent" disability benefits.—Monthly cash benefits would be payable to insured workers who are afflicted with serious disablements which have lasted 6 months or more.

Concept of disability.—Disability benefits should be payable only if there is a substantial loss of earning capacity for work in general. They should be payable only if the worker is found incapable of earning more than a small amount at any work which he might reasonably be expected to do.

Eligibility conditions.—To receive benefits, a disabled worker would have to be insured. The insurance requirement should be a test of both substantial and fairly recent covered employment. As in the case of old-age benefits, disability benefits would not be paid for any month in which the beneficiary earned more than the amount permitted under the retirement test. Also, benefits would be terminated if recovery occurred.

Extent, types, and amounts of benefits.—More than half of the cases of protracted disability occur at ages under 55 when the worker has heavy family responsibilities and has not had an opportunity to build up adequate protection through savings or insurance. In order for a disability insurance program to meet the test of social adequacy, benefits should be paid to persons with dependents and in relation to the number of depedents. The disabled worker should receive a monthly benefit computed in the same way as the benefit of an agend, retired worker; the wife (if she has a child entitled to benefits in her care or if she is age 60 or over) and children of a disabled worker should also receive benefits. Their benefits should be computed in the same way as benefits for wives and children of retired workers.

Intergration with old-age and survivor insurance.—Under the existing program a period of nonemployment due to disability reduces the benefits for which the worker or his family may subsequently qualify, and may cause the complete loss of insurance protection. If disability benefits are added, the worker's insurance protection would be maintained during a period of disability.

Vocational rehabilitation.—Expenditures for rehabilitation should be authorized from the trust fund to rehabilitate the disabled workers vocationally where a promise of success exists. If the rehabilitation is successful, the payment of benefits can be discontinued.

Adjustment of duplicating benefits.—Because benefits should not be in excess of the individual's previous wages, consideration should be given to provisions for adjusting duplicate benefits between different disability systems.

5. *Financing of expanded old-age, survivors, and permanent disability insurance program*

Strengthening the actuarial basis of the program.—The recommendations for changes in the coverage of the old-age and survivors insurance program should strengthen the actuarial basis of the program both in the immediate years ahead and in the long run. Contribution income of the program would be increased while at the same time the relative cost of insurance benefits paid to the group of individuals who move between uninsured and insured employments would be reduced. Benefit disbursements would be increased particularly in the early years so that under the expanded plan the relative cost of all benefits in the early years would represent a higher proportion of ultimate disbursements than under the present law. Consequently, since the slope of the benefit curve will be less steep, the expanded program would be a safer and sounder plan from both an actuarial and financial point of view and at the same time provide for substantially increased social insurance protection.

Long-run financial plan essential.—A long-range plan should be developed to assure that ample funds will be available to finance the benefit disbursements not only in the years immediately ahead but in the more distant future, without necessitating abrupt changes in premium rates. The contribution rates in the present law are as follows: 1 percent each on employers and employees during 1947, 1948, and 1949; 1½ percent during 1950 and 1951; and 2 percent each for 1952 and thereafter. These contribution rates will probably provide enough revenue to cover disbursements under the expanded program for 10 years or more.

Division of costs.—With practically complete coverage of the gainfully employed and their dependents, a Government contribution toward financing the program becomes equitable and appropriate. A Government contribution toward the program would be offset by the reduced public costs for public aid if coverage is extended and permanent disability benefits are included. Distribution of the ultimate cost of these benefits among employers, employees, and the Government should be made in the light of the degree to which coverage is extended and the financing of other types of social insurance benefits.

Cost of the present program.—The actuarial estimate of the original 1935 law indicated that the "level premium cost" of the benefits (the average contribution rate required to finance the system into perpetuity discounted at interest) would be slighly in excess of 5 percent of pay roll. Subsequent studies based on "probable maximum cost" assumptions, showed a level premium cost of 7 percent of pay roll.

When the program was revised in 1939, bringing in survivors insurance and providing for higher benefit payments in the early years, increased costs were counterbaalnced by a reduction in average benefit payments in later years and a reduction in lump-sum death payments. The level premium cost of the 1939 law, therefore, was about the same as for the 1935 law. Actuarial estimates made at the time of the 1939 law indicated that the level premium cost of the plan was from 4 percent of pay roll for the low estimate to 7 percent of pay roll for the high estimate.

The level-premium cost of the present law based on actuarial estimates published in 1947 is estimated to range between 3 and 7 percent of pay roll. These estimates are lower than previous estimates. The war and its aftermath, as well as the recovery from the depression of the early thirties, have been accompanied by important changes in many of the factors which determine the relationship between benefits and contributions under the program. Among the more important factors which have led to a reduction in the cost estimates measured as a percent of pay roll are the increased level of earnings and the expanded employment in covered occupations.

These revised figures are predicated on the maintenance of existing wage levels over the next 40 or 50 years. However, our history indicates that the Nation in the future is likely to have a level of income and earnings above that now prevailing. Increases in the past have been uneven; but, on the whole, they have been persistent over the decades. If the cost estimates of the present benefit provisions were amended to take account of a long-term tendency for wages to increase the range of the level-premium cost might be reduced from 3 to 7 percent to 2½ to 6 percent.

Cost of an expanded program.—Utilizing for illustrative purposes the 1947 actuarial estimates based on present employment and wage levels, the level-premium cost of a revised and expanded program would total between 5½ and 8½ percent of pay roll, or not much more than the present system was estimated to cost in 1939. The ultimate annual cost of the expanded program based upon the above assumptions is estimated to range from between 7½ percent of pay roll to 12 percent. This is a reduction in the range for the 1935 law (9.4–14.6 percent) and not much different than the range for the existing law as estimated in 1939 (7–10½ percent). However, it is of course higher than the estimates of the cost of the 1939 benefits measured as a percentage of present day pay rolls (4–8 percent). The explanation of the paradox of being able to grant more liberal benefits, both as to amount and type at apparently the same cost in terms of pay roll, is as follows: First, the change in the benefit formula, in general, parallels the changes in wages which have occurred in the past 8 years, so that benefits under the new formula, on the average, will bear the same relation to wages as the benefits under the present formula bore to the lower average wages prevailing before the war; thus, the change in the benefit formula can be said to be not a real liberalization, but only a maintenance of the same level of relative adequacy that prevailed when the program was enacted. Second, the additional types of benefits and benefit liberalizations have their cost borne largely by the savings due to extending coverage.

Cost of an expanded program in terms of percentage of pay roll

Recommended change	Level premium cost	
	Low cost assumptions	High cost assumptions
	Percent	*Percent*
Cost of present law	3.2	5.5
Extension of coverage	−1.0	−1.7
Age 60 for women	+.5	+.7
Lump sum for all insured deaths	+.1	+.1
Revised work clause	+.4	+.3
Permanent disability	+.5	+.8
Revision in benefit formula and computation of average wage	+1.7	+3.0
Cost of expanded plan	5.4	8.7

Senator Donnell. Doctor, in your mimeographed statement, copies of which you have furnished to the members of the committee, you say after the sentence referring to 6 percent for employees: "That is the amount which Arthur J. Altmeyer, Commissioner for Social Security, has just proposed to the advisory council of the Finance Committee." Are you referring to $4,800?

Dr. Shearon. $4,800.

Senator Donnell. You mentioned percentages.

Dr. Shearon. I was referring there to the amount.

Senator Donnell. $4,800.

Dr. Shearon. Do you think I should insert something there to make it a little bit clearer? It is the amount that he has proposed.

Senator Donnell. The dollar figure. He does not mention the 6 percent to which you refer.

Dr. Shearon. That figure has been mentioned in the past and then in one of the bills, in one of the comprehensive bills in 1945, S. 1050, it was lowered to 4 percent. Six percent was proposed in the 1943 comprehensive Wagner bill, S. 1161.

Senator Donnell. It specified 6 percent?

Dr. Shearon. It specified 6 percent there, and then in 1945 specified 4 percent.

Senator Donnell. Well, now in S. 1161 did it specify 6 percent on employers and 6 percent on employees?

Dr. Shearon. That is correct.

Senator Donnell. In the 1945 act that was S. what?

Dr. Shearon. S. 1050.

Senator Donnell. There it was reduced to 4 percent on employers and 4 percent on employees; is that right?

Dr. Shearon. That is correct, and then in order to make up for the losses because there will be deficit financing, we don't know how much deficit financing, it was clearly stated the Congress would have the authority to make appropriations from general revenues into the social insurance fund to take care of various, shall we say, grants-in-aid-programs, and also to make up deficits that is clearly specified, but you see, when they reduced the tax from 6 percent in the '43 bill to 4 percent in the '45 bill in order to take care of the decreased revenues, they were doing two things.

They were increasing the wage amount on which the taxes would be paid from $3,000 first up to $3,600 and now up to $4,800 in the proposals, and they also are opening the door for Congress to take care of the deficit financing through appropriations from general revenues.

During the first year of operations benefits would not be given, but staff would be hired and rules and regulations written.

In other words, you have got to allow the system time to get into operation. It covers the whole country, and they would have to hire a staff and get ready to do business.

Senator SMITH. Doctor, I see the rules and regulations cover quite a number of pages. I wonder whether it would be your preference to stop—we have to adjourn in a few minutes. We could pick this up when we meet again, so we could have the whole picture. Otherwise you would have to repeat it to catch up.

Dr. SHEARON. I think you are quite right.

Senator SMITH. If you are ready to stop at this point, I suggest that we do that. My colleagues approve, and so we will adjourn until Wednesday morning at 10 o'clock, when Dr. Shearon will continue.

(Whereupon, at 11:55 a. m., the committee adjourned, to reconvene at 10 a. m. on Wednesday, February 4, 1948.)

NATIONAL HEALTH PROGRAM

WEDNESDAY, FEBRUARY 4, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee room, Capitol Building, Senator Forrest C. Donnell presiding.

Present: Senators Donnell (presiding), Smith, and Murray.

Senator Donnell. The committee will come to order, please.

Let the record show that Senator H. Alexander Smith finds it necessary to be somewhat detained this morning and has asked that I proceed to call the committee to order and to go ahead with the matter at hand.

So, Dr. Shearon, will you kindly resume with your testimony?

Senator Murray. Before the doctor proceeds with her testimony, Mr. Chairman, I have a letter and an article prepared for publication by a correspondent for various insurance concerns, and I ask to have this printed in the record.

Senator Donnell. Without objection, then, it will be so done.

(The documents referred to were withdrawn by Senator Murray in the proceedings of February 5, 1948.)

FURTHER STATEMENT OF MARJORIE SHEARON, Ph. D., DIRECTOR OF THE SHEARON MEDICAL LEGISLATIVE SERVICE, WASHINGTON, D. C.

Dr. Shearon. I have just gotten to the point of discussing——

Senator Donnell. Pardon me. I observe this relates to the activities of Dr. Shearon. I think it would be well to let Dr. Shearon see this at some time before she gets through with her testimony so that she may know what is in it.

May Dr. Shearon be permitted to see this?

Senator Murray. Yes.

Senator Donnell. This is a letter from Mr. Al Goldsmith, in which the statement referred to by Senator Murray is enclosed.

Proceed, Doctor.

Dr. Shearon. I was discussing the philosophy and implications of S. 1320.

Senator Donnell. We have got to the top of page 12 of your mimeographed statement.

Dr. Shearon. That is correct.

Senator Donnell. Very well.

Dr. Shearon. I was just going to discuss the question of rules and regulations. This a rather dry, but an extremely important, subject.

In this connection, I would point out that there has been no discussion before this subcommittee of the rules and regulations of compulsory sickness insurance, yet they are of infinitely more importance than the provisions of the basic statute.

In other words, I think you all realize that within a few years you probably wouldn't recognize the basic statute, because it would be revised over and over, and the real controlling influence in the lives of the people will be the rules and regulations which are written in the department that administers the law.

Whereas the members of Congress enact the original law, thenceforth it is the Federal officials in the Executive Departments who write and enforce the rules and regulations which have the force of law.

Senator Donnell. Pardon me, Dr. Shearon. I find myself somewhat at a loss to agree with the statement that regulations and rules can be of infinitely more importance than the provisions of the basic statute, and I am wondering whether your meaning is quite that language.

Now I can well understand how the practical contacts of the public would be more with the rules and regulations than they would be with the statute itself, and in that sense, I can appreciate the force of what you say. It would appear to me, however, that the statute itself, being the fundamental basis under which the rules and regulations derive their existence, must necessarily be of primary importance, even though the rules and regulations are the items with which the public most generally comes in contact.

Would you mind elaborating as to just what you mean there?

Dr. Shearon. I will be very glad to explain what I think about it.

There is usually a little sentence in the basic law which gives the administrator of the law permission to write the rules and regulations. Now, the basic law doesn't go into a very great many things at all. It simply gives blanket authority to the administrator of the Executive Department to write those rules and regulations. Now they come out in very large numbers, indeed, covering many subjects that are not touched on in the original law at all, and that, furthermore, the original legislators had no knowledge of and didn't know were going to be in the rules and regulations.

That is why I really feel the rules and regulations become of much greater significance eventually than the basic law, which is comparatively short. I don't say that S. 1320 is very short, but by comparison with the rules and regulations, the basic law is simply lost in the shuffle. In other words, it does give a blanket authority, which I feel is the thing that makes the bill so much more comprehensive and so much more dangerous than one would think from just looking at the law itself. When you looked at the bill, you might say, why, this looks like a pretty good bill. Before you enact it, the objectives look very fine; they are objectives that I suppose everyone would agree with. The basic law itself doesn't contain some of the things which we know are going to come out in the rules and regulations. I mean that is my own explanation. You as a lawyer in the Legislature might feel that the basic law is more important.

You get a volume of rules and regulations, say, that number several thousand, and they are enforced. You could in time change the basic law—that was done in Germany—so that there was practically nothing left of it, but these rules and regulations would still be in force.

Senator DONNELL. The thought that I have, Doctor—I don't know that it is necessary to consume much record on it; after all, each person is entitled to his own view—is that obviously the rules and regulations can only derive their validity from the underlying provisions of the statute. Therefore, what seems to me to be of primary importance is the statute, although I can well understand how the rules and regulations might disclose many applications of the statute that would not suggest themselves to the mind of the reader of the statute as he proceeds in reading it.

I didn't mean to interrupt indefinitely your presentation.

Dr. SHEARON. I am very glad you brought that out.

I think the Chief Justice in Great Britain, in his volume entitled "New Despotism"——

Senator DONNELL. Chief Justice Jowett?

Dr. SHEARON. No—Lord Bury, the one you met when you were over there. I think I have his book with me.

Senator DONNELL. I have had the pleasure of seeing Lord Chief Justice Jowett.

Dr. SHEARON. The point I was making is that in "New Despotism," and referring particularly to compulsory health insurance, as they call it there, he referred to what might be done under rules and regulations which are never tested in the courts. In other words, if we were to take some of these rules and regulations to the Supreme Court, you might find they wouldn't be upheld. But nobody has the time or money or the patience to go to the Supreme Court with 2,000 rules and regulations, let us say. Yet, so far as the people are concerned who come under those rules and regulations, they have the force of law, and the appeals system within the Government is so, shall we say, complicated and tiring that people just don't even try to appeal. I mean that is my point of view, and, as you say, there would be different points of view.

It was Lord Hewit.

Senator DONNELL. He spoke here before the American Bar Association some years ago; I believe he did. I am not positive that he is the one who did.

Dr. SHEARON. That is correct. He wrote the book on "New Despotism" in which he develops the thesis that the executive departments in Great Britain had taken over the authority of the legislative branch of the Government, just as they are doing in this country. So there is a strong parallel.

Senator DONNELL. Pardon me. Off the record.

(A discussion was had off the record.)

Senator DONNELL. Will you proceed now, please?

Dr. SHEARON. The number of such rules and regulations is staggering. So is their complexity. By the time social insurance had been in operation 40 years in Germany, the number of laws, ordinances, and interpretations was so voluminous that a prominent expert in that country stated, and I quote:

> There is no longer a single specialist in Germany who knows even superficially the principal features of social insurance.

Yet fewer than 40 million persons were involved as against our 143 million.

During the 1920's, and I continue the quotation——

Senator DONNELL. From whom are you quoting, Doctor?

Dr. SHEARON. It is a quotation taken from a book by Walter Sulzbach. I had a copy of this for each one of the Senators on the desk last week, I think; probably they are still here.

Senator DONNELL. It is his work on German experience in social insurance?

Dr. SHEARON. Yes. It is a new book, just published, and it is a quotation taken from it on page 2.

Senator DONNELL. All right.

Dr. SHEARON. In this quotation, it says, during the 1920's—that is not in the quotation; then continuing with the quotation—

> so many changes in the German laws on social insurance were made that the pertinent commentaries were no longer published in book form but in catalog form, so that any entry could quickly be replaced by another. Alterations were so numerous that the comprehensive laws which were enacted in 1911 had to be completely reenacted thirteen and fourteen years later.

That is one of the things that I had in mind.

In Great Britain, where only 40 percent of the population, that is approximately 20,000,000 workers, was covered by national health insurance, the number of rules and regulations reached the staggering total of 2,000 within three decades.

I have often referred to this volume here [illustrating] and I will show it to you again. This is the book that contains the basic laws and the amendments thereto, their interpretations, and the rules and regulations for health insurance in Great Britain, where it was only for the workers and not for their dependents. It was just a portion of the population that was covered.

Senator DONNELL. Would you read into the record, please, the name of that book? We have referred to it frequently both by thickness and by weight.

Dr. SHEARON. It is a book by Henry Lesser, entitled "The National Health Insurance Acts, 1936–38," and it was published in London in 1939—one of the impressive points about it is that it is 1,281 pages long—to tell the people of Great Britain how they may obtain their medical care.

It required a volume of nearly 1,300 pages in length to cover the rules and regulations, the health insurance laws and amendments thereto, and the interpretations of these legislative, regulative, and interpretative pronouncements.

If such a volume of regulatory interference with the lives of the people was necessary in the small area of the British kingdom, where the population is reasonably homogeneous and the geographic conditions do not show great extremes, then I submit that the volume of regulations for a population of 143,000,000 in a country with the geographic variety and the social and economic differences found in the United States would be astounding.

Physicians, dentists, nurses, hospitals, and patients would eventually be overwhelmed by these compulsive rules, regulations, and laws. This is what is meant by compulsion and by unwarranted regulative interference with the daily lives of every person in the United States.

I refer at this time to my brochure entitled "Regulative Interference Under The Wagner-Murray-Dingell Bills," which I would like to have incorporated as one of the exhibits.

I have these exhibits because I have quite a sizable bibliography in each one of them, and it seemed to me it would be easier, rather than to break down my own testimony with all these bibliographies, to give it in printed form.

Senator DONNELL. Without objection, it will be accepted into the record.

(The document submitted by Dr. Shearon is as follows:)

REGULATIVE INTERFERENCE UNDER THE WAGNER-MURRAY-DINGELL BILLS

LEGISLATION FOR THE NATION'S HEALTH NOW IN THE POLITICAL ARENA

For the first time in the history of the United States, national health legislation was thrown into the political arena when, on November 19, 1945, in a special message on health, President Truman urged Congress to act. In solving the basic problem of distributing the costs of medical and related services, he recommended "expansion of our existing compulsory social insurance system. This," he insisted, "is not socialized medicine." On the same day, S. 1606, one of the series of Wagner-Murray-Dingell bills, was introduced.

Hearings lasting 31 days were held on S. 1606 before the Committee on Education and Labor in 1946. Over 200 witnesses were heard. But the committee failed to report the bill to the Senate before the Seventy-Ninth Congress came to a close.

On May 20, 1947, a new Wagner-Murray-Dingell bill, S. 1320, was introduced in Congress, the day before hearings were to start on S. 545. Again there were prolonged hearings on the question of establishing a national system of medical care insurance. The hearings, held before the Senate Committee on Labor and Public Welfare, were recessed on July 23, 1947, and will be concluded early in the second session of the Eightieth Congress.

President Truman, in his State-of-the-Nation Message on January 7, 1948, reiterated his request that there be established a national system of medical care insurance. He has accepted the concept of Federal compulsion in the field of medical care for individuals. The present administration is supporting national compulsory sickness insurance as an integral unit in the comprehensive Social Security System. Legislative blueprints to make compulsory sickness insurance part of the law of the land are to be found in S. 1050 and S. 1606 of the Seventy-Ninth Congress and in S. 1320, S. 1679, S. 1714, and S. 1734 of the Eightieth Congress.

The issue of whether or not it is desirable to have the Federal Government provide medical care, hospitalization, and other health and medical services to the entire population of the United States is no longer a matter merely for academic discussion. It is now a political issue to be fought out in a presidential election year. The President and one party have declared themselves in favor of national compulsion. Where should we stand as individuals—as patients and practitioners, but first of all as American citizens?

What is the origin of the legislation? Who wrote it? Why does it arouse such vehement controversy? Is it fraught with dangers as claimed?

BISMARCK'S SOCIAL INSURANCE

The whole series of Wagner-Murray-Dingell bills of 1943, 1945, and 1947, insofar as they relate to compulsory sickness insurance, find their prototype in the insurance laws of Bismarck. During the decade of the 1880's Bismarck, acting on the recommendation of his economic adviser, Adolph Wagner, professor of political science at the University of Berlin, laid down the general principles of social insurance. Laws of sickness insurance, accident insurance, and old-age insurance were enacted despite bitter opposition. It has been said that Bismarck's aim was, "first to muzzle the official Social Democrats, and then, by a series of small bribes, to wean the proletariat from their adherence to revolutionary principles." (*1*).

Bismarck translated into law the theories of the man who is credited with having done more than anyone else to give to state socialism its "scientific form and scientific foundation." Professor Wagner's social philosophy and total program for State control were outlined in an article published in 1887 in which he advocated (1) public ownership of banking, insurance, communications, and utilities, and (2) State "insurance against sickness, incapacity, and old age."

He likewise proposed and justified a new scheme of taxation that would not only serve the legitimate purpose of raising revenues but would at the same time fulfill the purpose of what he called "regulative interference."

This "interference" was to operate by regulating first the distribution of income and wealth and second the purchasing power and living habits of the "lower classes." The latter form of "interference" was to be accomplished "by administrative measures, and eventually by compulsion." Wagner stated, "This two-sided policy of taxation I call social. The second side here advanced * * * is based, as concerns the mass of the population, the lower labouring classes, on the assumption that in the truest interests of the nation a guardianship may and must be exercised over the national consumption or over the application of income to personal purposes." (*2*).

These "social" insurance laws, thrown as a sop to the Socialist Cerberus, were acclaimed as "the high-water mark of German state socialism." (*3*.) Designed to quiet the complaints of the Socialists and at the same time to ease the burden on the local governments for care of the sick poor, they were preeminently political and economic devices rather than health measures. The law of sickness insurance was passed without the professional advice of health and medical experts; and administrative control was placed in lay hands. Bismarck, it is to be remembered, was hard-pressed for funds. He was seeking new sources of revenue. In the guise of what he called "practical Christianity," (*4*) he induced the Reichstag to approve his new plan for taxing the workers thereby making them shoulder the burden of most of their own poor relief. In return for their acceptance of the principle of "compulsion" and of control by a powerful bureaucracy, the "lower classes" were promised certain pitifully small and limited benefits which they might claim as a "right."

German sickness insurance was financed by taxes on employers and employees, the workers, until as late as 1934, paying two-thirds of the cost. The government provided the compulsion and interference; labor and management footed the bills. The doctors were squeezed between the upper and nether millstones of regulation and interference. Benefits were of two kinds: a cash sickness benefit equal to not less than one-half the daily wage, and free medical and hospital care during illness. Minimum benefits were for 26 weeks with optional extension to 52 weeks if funds were available . Small maternity benefits and death benefits were also provided. Originally coverage was limited to low-paid workers in a few occupations; ultimately it was extended to all manual workers and all others with incomes not exceeding 3,600 reichsmarks annually, so that, with dependents, two-thirds of the population was covered. Under the law total "contributions," the euphemistic name given to the new taxes, could not exceed 7.5 percent of earnings and usually were limited to 6 percent. There was no state subsidy.

The Bismarck plan of social insurance has been adopted in over 30 countries generally as a political, fiscal, and regulatory device. The schemes for compulsory sickness insurance have in the main followed the original pattern. While details vary from country to country the distinctive characteristics of compulsion and regulative interference persist. Indeed, they are integral parts of the scheme and are, as many persons believe, the inherent cause of its weakness. Some countries have broader coverage, others more restricted. Great Britain insured only 40 percent of the population, and excluded dependents of workers. Russia, on the other hand, covered the entire population and carried the compulsory scheme to its logical conclusion by making all physicians the salaried servants of the state. New Zealand attempted complete coverage and a mixed system of payment for physicians. Thus, the framework and essential structure of the compulsory insurance features of the Wagner-Murray-Dingell bills are neither new nor original. They are a composite of Old-World statutes written in such a manner that they may be incorporated into a comprehensive system of federally operated and controlled social insurance.

In considering the sickness insurance bills now pending before Congress it would seem to be advisable to investigate the efficacy of the Bismarck plan. How well has it worked in the 60 years of its operation? Has it been administratively satisfactory, politically desirable, and medically sound?

Some of the answers to these questions are to be found in an appraisal of the German system made by the Federal official who is mainly responsible for the health and medical provisions of the Wagner-Murray-Dingell bills and who is generally credited with being the leader of the movement to establish Federal compulsory sickness insurance in the United States—Isidore Sydney Falk, Director of the Bureau of Research and Statistics, Social Security Administration. (*5*) After studying the German and other European schemes, Falk stated in 1936:

"Observers are in general agreement that the German sickness insurance laws and the central administration are very complex. For this there is a simple historical explanation and, perhaps we may say, justification. When first conceived, Bismarck contemplated a system which would absorb the existing insurance societies and provide for the formation of new ones. The state did not intend to contribute to the insurance benefits; the scheme was to be a mutual undertaking between employers and employees which the state was to supervise and regulate. In consequence, the benefits would be only those which the contributions from these two classes could finance.

"The state wished to make benefits appear as attractive as possible; but it dared not promise more than the contributors could and would support. The laws were therefore framed on the principle of specifying the minimum benefits which must be furnished and the maximum contributions which may be required. The system had to be framed to cover widely differing conditions among urban and rural communities and to meet the needs of all industrial classes, from the most substantial down to the dependent poor. Flexibility was therefore essential, and *flexibility meant various, diverse, and complex legal provisions*." (*6*)

The author of the volume on European sickness insurance to which I have just alluded then goes on to point out that the insurance societies responsible for administration of sickness insurance funds had devoted too little money to public health activities, spending in some years as little as 5 or 6 cents a person for the improvement of health. "In spite of evidence of improvement in this respect, sickness insurance in Germany has not been as completely as it might be 'health insurance'." (*7*) It is further admitted that German insurance practitioners were underpaid and suffered from lay controls.

"From the outset, the insurance societies contracted with physicians to provide medical service and, of course, some of them sought individual physicians who would accept low rates. These were not always the best practitioners available to serve the insured population. Long and acrimonious wars have been fought among the societies, the professions, and the insured persons over the questions of 'free choice of doctor', 'professional freedom from lay control,' 'adequate professional income,' 'red tape,' 'certification for disability,' etc. (*8*)

In the light of these facts one may wonder why the Federal official who saw all the defects of compulsory sickness insurance should have written into the successive Wagner-Murray-Dingell bills the very provisions which he admitted were provocative of discord and which were reasonably certain to lead to autocratic rule, red tape, and limitations of freedom. (*9*) The mixed system of remuneration of physicians which he has proposed has bankrupted the New Zealand sickness insurance scheme and might be expected to do the same thing in this country. (*10*)

It is being loudly proclaimed at this time that Federal sickness insurance legislation should be enacted forthwith in order to induce physicians to leave the cities and settle in rural areas. But the scheme did not have that effect in Germany where after 50 years' operation it was observed that "the physicians of Germany are located in excessive proportions in the large cities and in inadequate proportions in rural areas." (*11*) It has been stated repeatedly that the incomes of the majority of physicians would be improved under the provisions of the latest Wagner-Murray-Dingell bill. But insurance practice did not have that effect on the income of German physicians. In 1936 Falk stated that:

"The inadequacy of professional income is even more discouraging in Germany than in the United States because it bears with unusual weight upon the insurance practitioners; whereas the less-than-average incomes of most physicians in the United States are 'compensated' by the greater-than-average incomes of the others; in Germany the less-than-average incomes occur mainly among insurance practitioners whose clientele is among the poor, and the greater-than-average incomes occur chiefly among the non-insurance practitioners who serve private patients in the higher income classes." (*12*)

WHAT HAPPENED UNDER HITLER

It is significant to note that following the National Socialist revolution in 1933 Hitler reorganized Germany's social insurance system. At that time, "the government's medical program was looked upon by many as one of the greatest props of the totalitarian state." (*13*) The "leader" idea was introduced into the insurance system, and Hitler issued a series of decrees in 1933, 1934, and 1935. "The new law, the decrees, and the regulations have profoundly changed the arrangements under which medical services are furnished. Where hitherto the contract of service had been left to each fund to be negotiated with each doctor, it is now a central contract governed by law and regulation" (*14*).

The two leading professional organizations of German doctors were dissolved. Hitler gave exclusive legal status to the sickness insurance doctors of Germany (the K. V. D.). This group was given authority by decree to furnish medical services to insured and uninsured persons and to decide on remuneration. It was given responsibility for the "punishment of its members" (*15*). In this connection, I would point out, as others have before me, that a comprehensive Government sickness insurance scheme with its Nation-wide bureaucratic machinery lends itself to administrative abuses with peculiar ease when the central power passes to a sadistic leader of the Hitler type. Punishments are devised for physicians and patients; the rights of the individual are abrogated. This was done in Germany. It could be done here.

REGULATIVE INTERFERENCE

It is obviously impossible in this short statement to enter into an exhaustive discussion of the attributes of a compulsory sickness insurance program. I should, however, like to say a few words about the operation of the principle of "regulative interference." The claim is frequently made that compulsory sickness insurance does not change the practice of medicine. Patients, it is said, will be free to enter or to remain out of the system; physicians will enjoy similar freedom, it is claimed. Patients may freely choose their physicians from among those who have consented to become insurance practitioners and who have signed a contract with the Federal Government to abide by the rules and regulations to be issued in Washington.

Is this freedom? Patients would have about as much freedom as a prisoner in a Federal penitentiary would have if given the choice of working on the rock pile or in the prison laundry. Physicians on their part would be expected to make a blind date with the official in Washington who would one day promulgate the insurance rules and regulations which would have the force of law.

What about patients? Under compulsory sickness insurance, insured persons would be given the following degree of freedom: Once the law went into effect every insured person would be informed as to the doctors in his particular insurance district who had agreed to become insurance practitioners. If the panel or capitation system, such as is used in Great Britain, were adopted and which it has been admitted would be the pattern adopted here, there would be a limitation of, say, 1,000 or 1,500 patients per physician. Insured persons would be given a certain period of time to sign up on some doctor's panel. If they failed to act they would, after due notice, be assigned to some doctor by the Surgeon General of the Public Health Service or his local representative. Clearly there would be a rush to get on the panels of those doctors who were considered to be the best in the community—assuming that they would consent to enter the system. Persons who delayed or were recalcitrant would have to take the less satisfactory doctors or would compulsorily be assigned to doctors whose lists had not filled rapidly. Persons moving into a neighborhood after the capitation system had been set up would have to be content with the left-overs. If it so happened in a small community that none of the doctors was particularly good, insured persons would still be compelled to sign up with them and could not make arrangements with better qualified doctors in adjoining communities, unless they did so at their own expense in addition to paying their increased social security taxes and income taxes. Under the panel system of insurance practice the insured person becomes a pawn to be placed on panels at so much per head per year for the purpose of guaranteeing to physicians minimum incomes which tend in time to become maximum incomes.

Under the Wagner-Murray-Dingell bills specialists would be available, as a rule, only on the advice of the insurance doctor. Obviously there might be occasions when a patient would demand a specialist and the insurance practitioner in the interests of economy would refuse his consent. In such a case the patient would be compelled to refer his appeal for the services of specialists and consultants to the local medical admiinstrative officer appointed by the Surgeon General. Anyone who has endeavored to obtain quick action on an appeal to a Government agency in connection, let us say, with an OPA regulation, will appreciate that a critically ill patient would probably be dead before he could obtain a ruling on his "right" to specialist and consultant services.

This is what is meant by regimentation and regulation of patients. This, multiplied a thousandfold. It is claimed that under the Wagner-Murray-Dingell bills insured persons would receive "the best modern medical care." The bills do not so promise. Instead, they specify cheap and limited services. Hospitals, for instance, would be paid "not less than $3 and not more than $7 for each day of hospitalization, not in excess of 30 days." This implies ward service. Indeed, the language in the bills refers to payment for "essential hospital services, including the use of ward and other least expensive facilities compatible with the proper care of the patient." Always the emphasis is on economy, on the protection of the insurance funds rather than on the "best modern medical care" which is nowhere mentioned in the legislative proposals.

The claim is made that patients not only have freedom of choice of physicians but that they may change doctors if they are dissatisfied. Again, they have that brand of freedom that is permitted under Government dictatorship. If we may judge by the "freedom" accorded insured persons in other countries, it is perfectly clear that such limited freedom as may be enjoyed will obtain at the moment of entering the system. It does not mean freedom to pick the doctor you want at the time of sickness which may be months or years after the date of entry into the sickness scheme. In Great Britain, the patient seeking to change insurance doctors must obtain the written consent of the doctor who is being dropped and of the doctor whose services are sought. But the need for change generally arises as an emergency matter when minutes may mean the difference between life and death for the patient. Perhaps under the new dispensation death, before striking, will wait for an official O. K. from the Federal Security Agency.

We may presently be philosophical about Government red tape in connection with controls over industry, consumers goods, and prices. We may look forward to the day when such controls will be removed. There is something grimly humorous about interminable forms in triplicate and about the Government run-around by various control agencies, such as the late OPA. One may even believe—albeit with difficulty—that one still has a court of last resort when one is told that if dissatisfied with the ruling of the administrator in a regional office, one may, within 90 days, appeal to the authorities in Washington by filing the appropriate official forms (seven copies, please). If one is still dissatisfied there is a modicum of comfort in knowing that one may finally appeal to the Supreme Court of the United States. This routine may have elements of humor when inanimate goods are concerned. There would be nothing humorous if a life were at stake. Nor can it be argued that analogies are far-fetched.

The degree of regulative interference with patients and physicians under the British and German sickness insurance schemes is unbelievable. Consider the provisions of the German insurance code with respect to hospital treatment. Economy of administration is the dominant note. Thus, when it appears to an insurance practitioner that a patient should be hospitalized the code specifies that "the attending practitioner must prove the necessity of hospital treatment in writing." Furthermore, the code and contract regulations specify that:

"The consent of the sickness fund must be obtained before admission to hospital except in urgent cases. The patient's consent is not required (i) if the nature of the illness is such that treatment and nursing cannot be given at the home of the patient; or (ii) if the disease is infectious; or (iii) if the patient repeatedly disregards the doctor's instructions or the rules for the conduct of patients." (*16*) Is this regimentation?

The insurance system in Germany is policed by medical referees "in respect of the economy and the standards of medical treatment." Medical referee service centers are set up, there being one medical referee for every 25,000 insured persons. (*17*) These medical referees, among their many duties, "are consulted, if required, before admission of patients to hospitals."

Doctors are under strict control with respect to the prescriptions they may write. "The standard cost of prescribing per case treated is fixed in the national agreement for the whole country." If on investigation by a medical referee it is decided that an insurance doctor has written prescriptions that are deemed too expensive or has prescribed costly new drugs without sufficient justification, the doctor may be penalized by having the excess amounts deducted from his Government reimbursement. Such prohibitions ultimately lead to rigidity.

These are a few of the restrictions that hamper physicians under compulsory sickness insurance schemes. They are to be found in the rules and regulations in all countries having medical insurance benefits; such regulations are numbered by the thousand. This is what is meant by regimentation of doctors and patients. This is what lowers the quality of medical care and stifles initiative.

BASIS OF THE CURRENT BILLS

The International Labor Office has published an exhaustive volume entitled "Economical Administration of Health Insurance Benefits." The first part consists of 133 pages describing "The Principle of Economy in Administration of Health Benefits;" the second part consisting of 173 pages is devoted to "The Principle of Economy in National Laws and Regulations." There are rules for the conduct of patients, rules for doctors, rules for hospitals, rules for prescribing, etc. The basic law, complex as it is, is but a very small part of the regulatory machinery of sickness insurance. Thus, in Great Britain the laws of national health insurance, the rules and regulations, and the interpretations thereof are set forth in a volume nearly 1,300 pages long (*18*) and every insurance practitioner has on his desk a volume of over 350 printed pages, known as the "Doctor's Bible," which informs him as to what he may or may not do. (*19*) The same administrative principles would inevitably be adopted in this country were compulsory medical care insurance legislation enacted.

It is of the utmost importance to realize that the successive Wagner-Murray-Dingell bills were not drafted along American lines but, rather, in direct conformity with international provisions which have been laid down by the Socialist-dominated International Labor Organization. These in turn largely reflect the German viewpoint with respect to the nationalization of medicine and the concentration of power in central governments. (*20*)

DEVICES FOR CENTRALIZED CONTROL

With reference to the two 1945 Wagner-Murray-Dingell bills and the series of bills introduced in 1947, I wish especially to direct attention to the devices employed for the purpose of conferring vast power on the Federal Security Agency, and on the Social Security Administration. The Social Security Act itself, as amended, authorizes creation of a board of trustees of the Federal Old-Age and Survivors Insurance Trust Fund which shall be composed of the Secretary of the Treasury, the Secretary of Labor, and the Federal Security Administrator. This board of trustees is authorized to hold the Federal Old-Age and Survivors Insurance Trust Fund.

The Secretary of the Treasury, designated as the Managing Trustee of the Board of Trustees, is authorized by law to invest such portion of the trust fund as he deems advisable in "interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States." This statutory authority given to the Secretary of the Treasury confers great power upon him with regard to investment of the Social Security Trust Funds and even permits him to support the bond market. S. 1320 carries the statutory authority of the Secretary of the Treasury forward into the health field. A personal health service account would be set up on the books of the Treasury and the Secretary of the Treasury would be given powers comparable to those he now enjoys in connection with the Old-Age and Survivors Insurance Trust Fund. This would put under his control some $7,000,000,000 to $10,000,000,000 more of trust funds each year.

This pool of Social Insurance Trust Funds would be called the National Social Insurance Trust Fund. To it would be transferred all the present assets of the Federal Old-Age and Survivors Insurance Trust Fund. Into this fund there would pour all the new and greatly increased social security taxes—four percent of payrolls from employers and 4 percent from employees, plus 5 percent of the income (up to $3,600 or, as currently recommended, $4,800) of self-employed persons, and such other tax receipts as may be paid in the form of premiums for insurance for State employees and statutory beneficiaries, plus, finally the Government subsidy which may run as high as 50 percent of the cost of the comprehensive program. (In Great Britain it is estimated that 61 percent of the cost of financing the Beveridge plan will devolve upon the Exchequer. In New Zealand, after only 6 years of operation of an omnibus social security law, the program is absorbing 40 percent of the total tax revenues of the country and was requiring a 45 percent subsidy from general revenues in 1946–47.)

The Federal Security Agency, instead of the Bureau of Internal Revenue, would collect the social security taxes. It would play a dominant role in the management of the Fund. Although the health funds would constitute about one-fourth of all funds held in trust by the Federal Government for the National Social Security Program, the Wagner-Murray-Dingell bills do not include on the Board of Trustees any representative of the health and medical professions.

The legislation has been so drafted that the main administrative authority over the lives of the people in this country would ultimately be vested in the Federal Security Administrator, insofar as medical care insurance is concerned. S. 1320 states that all the statutory functions of the National Health Insurance Board, a dominantly nonmedical group, "shall be administered by the Board under the direction and supervision of the Federal Security Administrator," who himself is not a physician.

These may seem like unimportant details until it is realized that they are the essence of control. The statutory provisions which have been deftly woven into the Wagner-Murray-Dingell bills relate particularly to (1) control of the National Social Insurance Trust Fund, in which may some day be deposited upward of one-fourth the annual national income, (2) top policy-forming councils and boards, and (3) vestment of ultimate authority for administration of National Compulsory Social Insurance in the Federal Security Administrator, who is now being urged for a Cabinet post of Secretary of Health, Education, and Security. All these moves, administrative and legislative, are directed toward centralization of power and Federal control over the daily lives of the people

CAN THE WAGNER-MURRAY-DINGELL BILLS BE ACCEPTABLY AMENDED?

The suggestion has frequently been made that amendments should be proposed to the sickness insurance title of the latest Wagner-Murray-Dingell bill and that the bill might thus be made acceptable to freedom-loving Americans. This is like asking a builder to remodel Alcatraz into a California bungalow. One cannot have freedom within the framework of compulsory sickness insurance. It is political and bureaucratic double talk to speak of freedom and compulsion as conditions which may be enjoyed simultaneously. Perhaps the people of America wish to seek health under a scheme of nationalized medicine. But I doubt if that is the case. To the extent that they are "sold" on the idea they have been "sold" by glittering promises that cannot be fulfilled. And, I might add, they have been sold down the river.

It would be impossible for a mere 3 percent of pay rolls to deliver to the American people the type of best and complete modern medical care that has been promised. We would not have the facilities or the health personnel even a decade from now. It would take the full time of all the doctors in the country to spend as little as two hours a year on complete health examinations for everyone in the country. The gap between the promises in connection with the Wagner-Murray-Dingell bills and the possible performance is indicative of a lack of candor on the part of Government experts who withhold from Congress and the public the facts which they have in their possession and which should be made public.

If the companion Wagner-Murray-Dingell bill were to be enacted, the only thing that would be sure to materialize would be the proceeds of the tax provisions. Whether or not the Government could deliver the health and medical services it promises, the National Social Insurance Trust Fund would bulge with new revenues. A bureaucracy with undreamed of power would be established which would be felt in every one of the more than 150,000 political subdivisions of the United States. Every family would pay tribute to the Federal Security Agency for support of the system of nationalized medicine. It would be a case of tax, and tax, and tax—rule, regulate, and regiment, if this country were to enact National Compulsory Social Insurance.

ABOLITION OF PRIVATE PRACTICE OF MEDICINE

That such legislation would lead to the abolition of the private practice of medicine is freely admitted by the International Labor Organization in a recent pamphlet in which this statement appears: (*21*)

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. The *next step to a single national medical service is a short one. . . .*" [Italics mine.]

BIBLIOGRAPHY

(1) Russell, Bertrand, German Social Democracy, 1896 (London), p. 107.

(2) Quotation from article in Tübinger Zeitschrift, published in 1887 and quoted by Dawson, William Harbutt, Bismarck and State Socialism, (London), 1891, pp. 156–158.

(3) Dawson, W. H., loc. cit., 109.

(4) "Practical Christianity," speech delivered by Bismarck, April 2, 1881. The German Classics, vol. X, 1914, pp. 221–243.

(5) National Health Program, Hearings Before the Committee on Education and Labor. United States Senate, 79th Congress, 2nd Sess., on S. 1606, pt. 1, p. 191; Shearon, Marjorie, Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Regulative Interference, 1947, 3rd printing; Report IV of Subcommittee on Publicity and Propaganda of the House Expenditures Committee, 1946; and "The Man Behind the Wagner Bill," Medical Economics, Dec. 1947, p. 46, ff.

(6) Falk, Isidore Sydney, Security Against Sickness, 1936, p. 121.

(7) Loc. cit., p. 134.

(8) Ibid., p. 124.

(9) See testimony of Arthur J. Altmeyer before the Senate Committee on Education and Labor, Hearings on S. 1606, April 4, 1946, that I. S. Falk, Director of Bureau of Research and Statistics, Social Security Board, wrote the major portion of the provisions of S. 1606.

(10) Private communication from J. P. S. Jamieson, M. D., Nelson, New Zealand, dated July 7, 1947.

(11) Falk, I. S., loc. cit., p. 130.

(12) Falk, I. S., loc. cit., pp. 130–131.

(13) Health Insurance, Report of the Advisory Committee on Health Insurance, 1943, Montreal, Canada, p. 108.

(14) Falk, I. S., loc. cit., p. 138.

(15) Ibid., p. 138.

(16) Economical Administration of Health Insurance Benefits, International Labor Office, Studies and Reports, Series M (Social Ins.) No. 15, Geneva, 1938, p. 19.

(17) Ibid., p. 206.

(18) Lesser, Henry, The National Health Insurance Acts 1936–38, London, 1939, 1,281 pp.

(19) Harris, R. W., and Sack, Leonard Shoeten, Medical Insurance Practice, British Medical Assoc., 1937, 383 pp.

(20) Shearon, Marjorie, Blueprint for the Nationalization of Medicine, loc. cit., 1947, pp. 13–15, 21–24.

(21) Approaches to Social Security, International Labor Office, Montreal, Canada, 1942, pp. 50–51.

THE AUTHOR

Marjorie Shearon, Ph. D., scientist, lecturer, and legislative consultant, was formerly research analyst to the Senate Minority Conference (1945–46) and health consultant to the Senate Committee on Labor and Public Welfare (1947). Prior to that she spent nearly a decade in the Executive Branch of the Federal Government, 5 years with the Social Security Administration and 4½ years with the United States Public Health Service.

Prior to her 15 years of public service—Federal, State, and local—she was engaged in scientific research in the biological sciences, her original contributions to science being in the field of evolution. A fellow of the American Association of University Women, past fellow of several, national scientific societies, she is a member of Phi Beta Kappa and Sigma Xi.

She is the author of numerous scientific articles and of: Economic Status of the Aged; Health and Disability Legislation in the States: 1939; Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interferences; Federal Propaganda for the Welfare State; Paradise Unlimited—the Menace of the Police State; and Bureaucratic Control of Medicine. She is author of American Medicine and the Political Scene, a weekly analytical news release which she publishes as Director of the Shearon Medical Legislative Service.

Dr. SHEARON. This is the sort of thing that leads to the police state. This is the aspect of national compulsory social insurance which is not discussed by or with legislative bodies before national laws in this field are enacted. The people and the legislators are kept in the dark about the way in which such laws operate.

You may well ask if it would not be possible to avoid such complex administration. My reply is that I am convinced such avoidance is impossible.

National systems of compulsory insurance have been in operation for many years in many countries. Ingenuity has been taxed, experience has been accumulated. Administration of all social insurance programs and of compulsory sickness insurance in particular is cumbersome, confusing, compulsive. If there had been any simple way to administer social insurance for small population units of from 1,000,000 to 40,000,000 persons, that way would surely have been discovered in the 65 years since Bismarck's laws were enacted. There is not the slightest hope that a simple or bearable method of administration could be developed for a population of 143,000,000 persons.

Twenty years ago the International Labor Organization published an exhaustive volume on the laws of compulsory sickness insurance then in force throughout the world and set forth the principles to be followed in writing rules and regulations.

This [illustrating] is the volume here. This was 20 years ago.

Senator DONNELL. What is the title of that volume and how many pages are in it?

Dr. SHEARON. It is called "Compulsory Sickness Insurance." It is Studies and Reports, Series M, Social Insurance No. 6, Published by the International Labor Office at Geneva in 1927. It is 794 pages long. It refers to all the component parts in the laws and the administration throughout the countries of the world and the general principles as well.

Senator MURRAY. Does that cover compulsory-insurance systems in many different countries?

Dr. SHEARON. Yes; it does. It covers countries that at that time had such laws.

Subsequently, a special volume was published entitled "Economical Administration of Medical Benefits." That was also by the International Labor Organization. I have it here, too.

Senator DONNELL. What is the date of that?

Dr. SHEARON. This was in 1938, and is entitled "Economical Administration of Medical Benefits." This is Studies and Reports, Series M, Social Insurance No. 15, Geneva, 1938, and this is 332 pages long. The first part of it, I might say, is on general principles. The second part refers to the laws as they were actually working in the several countries which at that time had such laws. It also summarizes their rules and regulations. It couldn't give them all.

The whole philosophy underlying compulsory sicknes insurance is one of regulative control. There are rules for patients, for physicians, for nurses, pharmacists, hospitals, etc. Primary emphasis is placed on protection of the insurance funds, not of the patient. Everyone involved in the system—and under the proposals now before Congress, that would be everyone in the United States—would be compelled to be subservient to the Federal officials who would police the system or to the local representatives of governmental authority who in turn would be nothing more than remotely controlled proxies acting as peripheral contacts for the Federal Government.

In other words, the attempt, say, to decentralize would work out superficially. But after all, the people in the States and the localities who were representatives of the Federal Government or responsive to the Federal Government would be compelled to toe the mark in accordance with the rules and regulations and principles established in Washington, as it was in the days of the OPA which was decentralized.

Without my going into a lengthy discussion of the question of administration, I believe you will have no difficulty in picturing what would happen if such a system were set up in the United States. The whole country would have to be divided into administrative districts, similar perhaps to present school districts or police precincts. Whether the system were decentralized at the start, as is now proposed, or were ultimately operated wholly from Washington, as a result of pressure for centralization, the fact remains that some manner would have to be found to supervise a Federal program that would cover 143 million persons.

There would have to be thousands of administrative offices. Thus it presently requires over 3,000 employment offices for the administration of the United States Employment Service for a few million unemployed persons. When it came to setting up the offices for administration of compulsory sickness insurance, 3,000 offices would be a mere drop in the bucket. There are over 175,000 governmental units in the United States. Most of them would have to have some insurance staff.

Policing the sickness insurance system: In Germany there was a medical referee for every 25,000 of population. In view of the complexity of the benefits which are being proposed in S. 1320, I surmise a far larger number of medical and other referees would be required. Indeed, the number of investigative and other administrative personnel working either directly out of Washington or under remote control therefrom, which would be required to police the sickness insurance system is truly staggering. I cannot help thinking that such a corps of referees, inspectors, and the like, spreading out through our country to every village and town, would be a menace the like of which we have never known. Not a family, not an individual would be safe from the eternal police surveillance of the Federal sickness insurance administrative machine.

When I speak of policing the sickness insurance system, I refer to the administrative procedures that would be necessary to enforce the Federal rules and regulations and to insure that the Federal insurance funds were spent economically. A count would have to be kept of the number and cost of all prescriptions issued by all physicians. Whether this count would be kept by Federal officials or by local governmental officials who would report quarterly to the Federal Government, you can readily see that the task would be a tremendously costly one.

Similarly, there would have to be pricing bureaus to decide what prices should be charged by more than 80,000 pharmacists throughout the United States for the prescriptions for free medicines. Every druggist would have to report to local or Federal authorities on the number and cost of all prescriptions filled. These reports would be summarized and would ultimately reach Washington, where they would be analyzed statistically.

The purpose of such reports would be to keep down the cost of prescriptions and to see that neither physicians nor druggists were breaking the rules and regulations set forth by the Government in regard to the kinds of drugs prescribed, the quantity and the cost.

Senator DONNELL. Doctor, might I interrupt you just a moment to read into the record as applicable to that portion of your discussion which relates to rules and regulations just a little of the language of S. 1320 appearing in section 251 of the bill. It is under the heading:

> Part E—National Health Insurance Board; National Advisory Medical Policy Council; General Administrative Provisions.

On page 39, the following appears:

> The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

I think it might be well to have that in the record at least reasonably close to where your discussion of the rules and regulations was.

Dr. SHEARON. And I might say that physicians would be held to strict account as to the exact number of pills, or capsules, or teaspoonfuls of medicine they prescribed.

Now I am not being facetious in that the rules and regulations do get down to a fine point, and I think you will see the reason for it.

When the Federal Government says that it will pay for drugs and it sets up a drug fund in the Government and has some money in that fund, it has to be sure that the money goes around. The European rules and regulations were very specific as to the exact quantity of medicine. That is a part of the economic administration to which so much time is given by the people in Geneva to see to it that the funds are well cared for.

I have mentioned one small part of the administrative machinery that would be set in motion were such a law as this enacted. Multiply all this tenfold, or worse still, a hundredfold, and you have part of the picture of the administration of national compulsory sickness insurance. Physicians would be called on the carpet for overprescribing, though they would not be punished for underprescribing. If a Government medical officer proved a case against a physician, the latter would be fined or might have the cost of the prescriptions in question deducted from his Government pay. Patients could be compelled to go to the hospital, following the German scheme, and to submit to courses of treatment if such procedure seemed necessary to protect the insurance funds.

I might explain there that it sounds rather drastic, but if a patient had been told by his doctor that he should have a certain course of treatment and it was recommended that he go to the hospital and he didn't want to, he might say, "I don't want to go." But the doctor might under certain circumstances send him to the hospital because if he delayed, it would be more costly to the insurance fund later on. In other words, it might not be left to the patient to decide whether or not he wanted to risk his own life if he didn't want to go to the hospital.

In communities having a panel system such as has been in operation in Great Britain for 35 years, insured persons who did not select a Government insurance practitioner would be arbitrarily asigned to a doctor. That provision, of course, has been made in the Wagner-Murray-Dingell bills. In other words, if we do adopt a panel system—and it has been suggested that we would in this country—and persons were recalcitrant, they would, after due notice by the Government, be assigned to doctors. This is necessary, because under a capitation system, the people are regarded not so much as potential patients, but merely as potential sources of income for doctors who would receive so much pay per year for the persons whose names appeared on their official lists. In other words, if the doctors of a community are going to be paid on a capitation basis, they must receive that capitation fee, whatever it is, for everybody in the community, every insured person in the community, and ultimately, of course, everybody would be brought in. As Senator Wagner explained at the time the bill was introduced, S. 1606, I think, Senator Hill asked him what the coverage would be, and he said it would cover everybody. So we have to think, not what it would be in the beginning, but what it would be ultimately.

Changes planned in medical practice: It is not possible in a brief presentation such as this to go into the full implications of administration of national, compulsory, sickness insurance. But I wish to point out that such administration cannot avoid the methods of the police state. I wish further to point out that statements which have been issued by Federal officials and by other advocates of so-called medical care insurance to the effect that there would be no appreciable change in the present form of medical practice have not told the truth. Some of the changes which are contemplated are:

1. A gradual change from the present fee-for-service basis of payment to a capitation or full-time salaried service, or a combination of those two methods;
2. The gradual abolition of the private practice of medicine and dentistry;
3. The gradual abolition of individual practice;
4. Complete and absolute regimentation of patients and of health and medical personnel; and
5. Control of all funds to be expended for health and medical services.

Both the public and the Congress are being led to suppose that there will be little, if any, change in the present methods of obtaining medical care and hospitalization. Thus, Dr. Joseph W. Mountin of the Public Health Service in testifying on S. 1606 stated, and I quote:

> There will be no need for an official "authorization" for service of any kind; the patient will go directly to his doctor exactly as he does now. Only the problem of paying the bill out of his pocket at the time will be eliminated.

I submit, Senator Donnell and Senator Murray, that a statement like that makes the bill very appealing to the public. If you tell the public, everything will be just about the same as it is now, you go to your own doctor, just as you do now, you wouldn't have to get any official authorization, and the only difference will be that you will not pay for the service at the time that you get it, I think that is a very appealing line of talk. I think that all of us would say "Well, it would be very nice, indeed, to get all of the medical care and hospitalization we need, best modern care, and get it without any payment at the time that we get it." If that is all there were to it, I would be for it 100 percent.

That statement is untrue. To begin with, insured persons will be compelled to select their doctors in advance of the time when they are ill if the capitation system is adopted, as the proponents of this legislation claim will be the case.

Senator DONNELL. The statement which you say is untrue is the one that is quoted?

Dr. SHEARON. Yes, the one that I quoted that everything will be exactly as it is now.

I refer to the capitation system a great deal, because it is conceded and the witnesses have conceded that that is what we would come to after a little while, after the transition period. At the start, we probably would have a good many doctors clinging to the fee-for-service basis, but they couldn't finance the system on that basis; it is too costly, and therefore we would come to a capitation system. That is the one that is used in most of the reports to illustrate how the scheme would work. And so I use that system also to illustrate how it would work.

The patients, therefore, would be compelled to select their doctors in advance. They would be compelled to go to doctors in their several health-service areas if they wished to receive free services under the social security system.

Senator DONNELL. You say, Doctor, if I may interrupt, that certain persons will be compelled to select their doctors in advance of the time when they are ill. Would you explain that? When would the selection take place?

Dr. SHEARON. The selection would take place during the year, say, while the system was being set up and the taxes were being collected and staff was being hired and rules and regulations were being written, etc. At the end of that year probably, or 6 months or whatever time was found necessary to get the system under way, the people throughout the United States would be notified that the system was now ready for operation, and they would select their doctors. The doctors would be notified that they were to come into the system, if they wanted to and were willing to sign a contract with the Government to give services as the Government would require and to abide by the Government contract.

The names of the doctors would probably be posted in the post office or other public places—that is the way it is done in Great Britain—and people would go to the post office and look at the list of the doctors who had signed up with the Government.

Now admittedly in the beginning, which, of course, will be a very controversial period, many doctors would not sign up. There would be a time when you couldn't get a doctor of your choice. I can see also how it would operate one way or another. All the doctors would be compelled to come into the system, and if they didn't come in voluntarily, there might be such compulsive laws as the one that now threatens Great Britain and it also threatens New Zealand. There, by the way, they have a bill which has not been enacted but is held over the heads of the doctors in New Zealand that the private practice of medicine shall be abolished. In other words, all the doctors would have to come into the Government system.

Now, a person would go to the post office and look at the list posted there. If they were lucky enough to find their own doctor on the list, they would go to him and say, "I want to sign up with you," and get a card. And there would be other red tape. If they don't find their own doctor on the list, they had better make up their minds as to the choice of another doctor if they want to get the free benefits. Then they would go to some other doctor. That would be done, you see, when you get into the insurance system. You are not necessarily ill. You pick a doctor.

Senator DONNELL. You pick him out before you know what you are going to have cured.

Dr. SHEARON. That is right.

Senator DONNELL. For instance, a person would sign up at the post office for Dr. Johnson, not anticipating that he ultimately might have diabetes. He might want to select a diabetes expert rather than Dr. Johnson. But he signed up with Dr. Johnson, and Dr. Johnson would be his physician. Is that your point?

Dr. SHEARON. That is right. Dr. Johnson would be a general practitioner, an insurance doctor, of course. The patient wouldn't be able to go to a diabetes specialist unless his insurance doctor said he could. By and large, that would be the method that would be employed. That is written into the bill as a rule. You would not be permitted to go to a specialist. Of course, that doesn't work too much of a hardship in a country where there aren't too many specialists, as in New Zealand. They haven't even set up specialist services as yet. The doctors there are likely to be more all around general practitioners and the people are used to going to general practitioners.

In our country, we have a great many specialists, and people are rather alert to what they want to do. They may not always use good judgment and they may shop around, and that may be considered to be bad practice. The Government couldn't afford to let them do that. At the present time at least, they still retain their blessed privilege of making mistakes.

Senator DONNELL. May I ask you this question: Under S. 1320, suppose that you start out with this list in the post office, and the citizens have to go there and select the physician of their choice. Now suppose Citizen No. 1 went there and selected Dr. Johnson as the very man he wanted. Then, a year after that, this citizen is attacked with diabetes and he decided he would very much prefer to have Dr. Williams instead of Dr. Johnson. What would he have to do under S. 1320? Would he be entitled to go to Dr. Williams and get his services?

Dr. SHEARON. The statements have been very general on that, namely, if you don't like the doctor you have, you can change him. But the trouble of that is it takes too long to change your doctor. You have to fill out forms. In Great Britain, you have to get the O. K. from the doctor you have and the O. K. from the doctor that you want. If you don't get both O. K.'s, you can't make the change without referring to the insurance referee.

Well, now, you know the Government is surrounded by red tape. It is very annoying. There are plenty of things, like the OPA, where you couldn't get an automobile tire when you wanted to, or gasoline. And there is rent control, but it is very different when it comes to the question of a person who is ill. He may want to change his doctor right away. In an emergency, you may not be satisfied with the surgeon that you have, and you don't want to waste even an hour's time in making a change. That is one of the things that I have felt very, very strongly about, that people are going to be deprived of that privilege of making rapid changes.

It may be answered; "I think the answer to that would be to have Government officials on hand who can pass on these requests, these urgent requests," etc. But you would know that when changes have to be made, forms filled out, and O. K.'s received, it would just take too long in matters of serious illness.

Senator DONNELL. Suppose the patient had been attacked by a high fever. He might not be in a very good position to present applications and evidence and petitions to make the change. Is that your thought?

Dr. SHEARON. That is my thought, and he might not have members of his family at hand who could do that for him. I suggest you apply this to someone in your own family. If you had been hospitalized and you had had to call a surgeon and for some reason you wanted to make a change, you might want to do it very quickly. It might be a matter of a major operation. I might say that even in great clinics, the Mayo Clinic and other big hospitals where you go for an emergency, it isn't general practitioners that you are getting. You are getting specialists there. You still have some freedom of choice. You can say, "I don't want doctor so-and-so," who is a very great surgeon, but, "I want doctor so-and-so," who is another great surgeon. You want him for some particular reason. You have done some checking. Nowadays people, I think, are growing more and more intelligent about checking. We don't take to regimentation in this country, I think, as people in European countries do.

Senator DONNELL. Under S. 1320, take the case that I have cited of a person who is signed up with Dr. Johnson, then he develops, we'll say, a fever a year afterward and he wants Dr. Williams quickly instead of Dr. Johnson. Who makes the decision as to whether he can get Dr. Williams?

Dr. SHEARON. He has to go to both doctors. He goes to the doctor he wants to get rid of to get his O. K.; then he goes to the doctor that he wants to get his O. .K., to see if he can get off one doctor's panel and on the other doctor's panel. There are administrative reasons for that. If you have people jumping around, getting on and off panels, administratively for the Government that is very hard, but that is one of the inherent weaknesses of compulsory sickness insurance; namely, it is hard to administer it.

You can see the administrative difficulty the Government would be in if you have a list of a thousand patients on one panel, another thousand on a second panel. You don't want a few of them coming over here and others going over there or somewhere else. The difficulty arising with 143,000,000 persons in this country even just changing their address, let alone anything else, would be enormous.

Senator DONNELL. Would the patients under S. 1320, in addition to getting the consent of Dr. Johnson and Dr. Williams, have to get the consent of a Government official also?

Dr. SHEARON. Ordinarily. Of course, the rules and regulations have been partly written already in the Government, although the law has not been enacted, but——

Senator DONNELL. You mean they have already been written in part in our United States Government here?

Dr. SHEARON. Yes.

Senator DONNELL. Who has written those, do you know?

Dr. SHEARON. Well, I have one set that Mr. Falk has written—I have it right here with me—one set of how he thinks it will work out in the different levels of Government. That was for the 1943 bill. But here is the point. The rules and regulations have not been fully written. When I give you answers and say it will be this way or that way, I am giving you illustrations from the way in which it has worked out in other countries. I don't think that we have all the wisdom or smartness in the United States. They have tried real hard to make their laws work in other countries, and they have just about done all they could on the job. I think if they were able to find a simpler way to do it, they would have done it.

Anyway, Senator, if you yourself had to administer the law, you would see that you couldn't have patients switching around from one panel to another without setting up some regulation which would say you can switch at the end of the month or you can switch at the end of the quarter. In Great Britain, they generally switch at the end of the quarter.

I want to point out that you, as a patient, might say, "I now have a general practitioner whom I never visited. I want to go to the Mayo Clinic or to the Lahey clinic for a checkup. I just want to go there for a complete checkup and diagnosis to find out what is the matter with me." Well, you would have to find out from your insurance doctor whether you could do that, whether you could make a change from an individual doctor to a group of physicians. That is one kind of change that requires one kind of form. There are just hundreds and hundreds of forms.

Senator DONNELL. Well, in the event that it became necessary to secure some Government official's authority to make the change, is there any provision in S. 1320 which says who that governmental official shall be and what his qualifications are to be, and whether he himself has to be a doctor or doesn't have to be?

Dr. SHEARON. There are generally these regional representatives of the Government. I might say that at the time when that would occur, you would have to have a referee, or whatever you want to call him, pass on your change from one doctor to another. It could be, we'll say, that the original doctor didn't want to let go of you. After all, you represent a certain amount of money to him on his capitation list. If he wasn't a very popular doctor, he might not want to let you go.

Senator DONNELL. Then if you weren't satisfied with his refusal to let you go, you would have to go to some Government official rather than stay with him, is that right, under the general theory of S. 1320?

Dr. SHEARON. Yes.

The criticism has always been made that if the health insurance law runs smoothly, it wouldn't be so bad, but there are all sorts of exceptions that come up, and that is why you get so many rules and regulations.

Senator DONNELL. Perhaps I should not divert you from your discussion here.

Dr. SHEARON. I haven't looked at the bill for quite a little while, but it does make that provision for approval.

Senator MURRAY. Dr. Shearon, could a lot of this criticism that you are making be avoided by providing for a complete home-rule administration in each of the States of the Union?

Dr. SHEARON. You mean, Senator, supposing we had a compulsory insurance system in the States and we didn't have one under Federal control?

Senator MURRAY. I mean we would have a Federal system of insurance. We could provide the method of collecting the taxes, etc., but permit the administration of the act in each State to be carried into effect by local State organizations.

Dr. SHEARON. That has been suggested, of course, in your S. 1320. You are really trying to decentralize it there. I have two answers on that. First of all, you would still have control, it would all be under the control of the Federal Government, and the ultimate authority would be vested in the Federal Security Administrator.

Senator MURRAY. Well, the Federal Government would set up the general standards, but the act would be carried out in each jurisdiction, in each State.

Dr. SHEARON. Well, if you follow the European practice—and I think you would almost have to do that if you are going to have it—it seems to me you would have to have Federal rules and regulations for uniformity throughout the United States. I mean part of the scheme is to give a fair amount of uniformity on pricing standards, prescriptions, and the kinds of prescriptions, the kinds of drugs. That sort of thing would almost have to be on the Federal level. I don't see how you would avoid that.

Now supposing you go to the other extreme and have separate State schemes. No State has such a scheme, and they don't seem to want to have it. Even there, you would still have it under a governmental control, and you would have to break down the State into these numerous small districts. You would still have to have patients getting onto panels, whether you did that from Washington or whether you did it from a State office or even whether you did it from a county office. It would still mean you would be telling people to get on panels and that everybody had to get on. You would still be saying to doctors, "You have got to sign a contract with the Government," whether it was the Federal or State Government.

I myself would be just as much opposed to seeing it under a State scheme as under a Federal scheme, because I think Government control is inherent in sickness insurance. Take the trouble they have had in a place like New Zealand, where they have a population of less than 2,000,000. It is about the size of Colorado. It is sparsely populated. They have had trouble there inside of 5 years in doing just this sort of thing. They have something nearer to your bill than anything elsewhere, and they have it for the entire population. They have the same methods of making payment. I have a whole brochure printed on the New Zealand plan because it was too long to incorporate in my statement. They are dealing with a small population, not anything like the problems we have.

They don't have any cities larger than 200,000 or 300,000 population. There is no large industrial center. It is a much simpler situation, and they haven't been able to work it out there. Even if you took a State like New York or California, you would have a tremendous amount of regimentation. Just take it from the point of view of an administrator having to handle, say, 14,000,000 persons in New York. Of course, in your State, Senator Murray, with the wide-open spaces there, I don't know what you would do with the sickness insurance scheme.

I crossed your State this summer, and I would go miles and miles and miles and not see a living thing except a few trees. It wouldn't do your State very much good.

Senator MURRAY. That is true, of course, in the rural section of the State, but that could be taken care of by a separate program for the farmers.

Dr. SHEARON. That is right. It would have to be a separate program.

Senator MURRAY. It is very difficult to work out, I can see, a general program that would fit every section of the United States. For that reason, it seemed to me that with a general program, permitting grass-roots administration all over the country, we ought to be able to work out a program of this kind.

Dr. SHEARON. I certainly wish you could do it, Senator, but I don't see how you can. Take your own city of Butte, with a population of about 32,000, something like that. You would still have to tell all those people in that community, "Go to your post office and pick out your doctor." I mean there would be a regimentation even in a comparatively small area like that.

Senator MURRAY. It seems to me we would have very little difficulty there in handling the situation. The doctors there are all known. It is not a big city.

Dr. SHEARON. That is right.

Senator MURRAY. It only has a population of about 40,000, and it seems to me that it would be very simple.

Dr. SHEARON. Well, Senator, you like to pick your own doctor, don't you? I mean you like to pick the doctor for your family, don't you?

Senator MURRAY. I am not so excited about picking doctors. There is a big clinic in Butte and there is St. James Hospital. You can always go to those places and find out who the specialist is or who the proper doctor is to handle the case. I don't think there is much to be alarmed about wanting to select my own doctor. In fact, I think half the people make mistakes in attempting to select their own doctor; it would be better to get advice from someone. For instance, here in the Senate, we have a doctor that serves us. No one ever doubts his ability, his qualifications, and it just seems to me there is a lot of undue excitement about this proposition of selecting your own doctor. People go all across the country. A member of my family went all the way from Butte, Montana, to Johns Hopkins Hospital to be operated on, and when he got there, it was a totally different man that operated, and the operation was very satisfactory in every respect. So I don't think there is anything alarming about this proposition of having to get a particular doctor.

Dr. SHEARON. I pointed that out. I mentioned that before, Senator, that in an emergency or an operation, that is one thing. You go to a specialist. You deal with him for a short time and you may never see him again. Then you go back to your general practitioner, who, in a great many instances, is something more to you than just a doctor. He is your family physician and he knows the whole family.

That is a relationship that a great many people think a lot about. Maybe you don't care about that.

Senator MURRAY. Of course that is something largely in the past, too. I have had experience with the medical profession in my home city. I raised a large family.

I had a family doctor that attended my family for a great many years until he died, and another doctor was a very close friend of mine, the doctor who built up the Murray Hospital—no relation of mine; his name was Dr. Murray. He was a member of the American Medical Association and one of the very high standing members, belonging to the board of trustees.

Dr. SHEARON. Board of trustees of the AMA?

Senator MURRAY. And was a very, very close friend of mine. I have been on friendly terms with every doctor in the community, never had an argument with any of them with reference to fees, and paid them whatever they requested in the form of fees, so I don't get very much excited about this thing about getting some particular doctor.

I think in this country the doctors are educated in competent institutions and they generally come out with a very capable man.

Dr. SHEARON. That's right, but of course there are differences in personalities. You have had the freedom, as you say, to go from one doctor to another. You know all the doctors in the community, doctors in the Murray Clinic, doctors in the other places.

However, if you were tied up with one doctor you wouldn't be able to know those other doctors. You would be tied up on the list of the doctor you appeared on, and it might be the one doctor you didn't like.

Senator MURRAY. Well, it seems to me with a local administration that could be very easily put down. I can't understand why there should be any great stumbling block with reference to getting the proper doctor in an emergency. It ought to be a very simple matter.

Dr. SHEARON. Well, it may look very simple, but it doesn't work out that way in practice.

Senator MURRAY. Well, with home administration, home rule, grass-roots control of the situation, it seems to me that the doctors would be competent to handle those problems that you talk about.

Senator DONNELL. Might I make just a brief observation at this point? It appears to me that this bill, S. 1320, recognizes the fact that people generally do desire free choice in selecting their own respective physicians.

Dr. SHEARON. They make a great point of that in selling this bill. A great point has been made in the publicity about the bill, the people having their free choice.

Senator DONNELL. Not only that, it seems to me in section 101 of the bill at page 5, lines 7 and 8, it is prescribed there that, if I may read the language at the beginning of the section also:

> The Congress hereby finds and declares that * * * to promote the general welfare of the people of the United States, the Congress hereby establishes a national health program * * * to enable patients to have more effective free choice in selecting their physicians.

In other words, this bill seems to imply, as I see it, in that preambulatory part of it, that the authors of the bill think that they ought to have even more freedom of choice than presently exists and I know that

Senator Murray, who is tremendously interested in this matter and has devoted so much time and thought to it, has mentioned at times, as I recall it in previous testimony, that there are certain restrictions today on the free choice of physicians arising from the small number of physicians that may be available, but this bill, S. 1320, I should say, seems to realize and recognize, at page 5, the great importance of enabling patients, as the bill says, to have "more effective free choice in selecting their physicians."

Now in addition to that I notice over on page 9 some language which I shouldn't be surprised would be used as an answer to certain of the testimony given thus far by Dr. Shearon on this point. I would like to comment very briefly on that. Section 203 prescribes:

> Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital or other person of his choice to render such services, and may change such selection.

Now, then, I am going to read the proviso in a moment. That language I think distinctly recognizes the thought in the minds of the drafters of this bill that there is merit in the right of people to freely select their own physicians.

Dr. Shearon. That's right.

Senator Donnell. My own personal opinion is I think I would like to select the physician as near as I could that was going to act generally. I can realize in an emergency case that I might have to take somebody that was selected by some governmental official or some municipal officer, but generally speaking I would like to have something to say about it myself, I believe.

Senator Murray. Well, Mr. Chairman, I agree with you on that completely, but at the same time I think what I am trying to get at is the proposition that sometimes it is necessary for you to take the advice——

Senator Donnell. Yes.

Senator Murray. Of an expert in selecting——

Senator Donnell. Oh, yes.

Senator Murray. In selecting a physician.

Senator Donnell. Yes.

Senator Murray. For instance, we are told by physicians every day that we should go to some specialist in some other part of the country. I had occasion just this last summer when I was out in Montana to send a woman from Butte, Mont., to Portland, Oreg., to be treated because a doctor in the local community told me that she probably had cancer.

I sent her out there at my expense and the doctors out there told her that she didn't have cancer at all; she had a case of anemia.

Now we happen to depend upon doctors to advise us, and I think there is nothing that is inconsistent with what I have in here at all. When we say "more complete free choice," or that language you just used a moment ago, it means, I suppose, that in addition to selecting a physician in the local community, that we should have choice of some experts in some other part of the country, if necessary, on the advice of local doctors.

I don't object, I am not backing up on the proposition of free choice at all, but I think that there are a lot of reasons why we should think that the person himself is unable to make the choice without the assistance or direction of somebody in the field that knows something about the case.

Senator DONNELL. Well, I can appreciate the point the Senator makes, and I think there is a great deal of merit in that in many instances.

However, it seems to me that even though we may procure the advice of medical authorities as to going to some specialist, that after all each of us, at least I personally would like to have some power to make the ultimate decision as to whether I go to him. Maybe I have the highest respect for the advice given, and yet there may be some lack of confidence, there may be some psychological phase that I just wouldn't want to go to that man.

Now, for instance, the Senator has referred here today, as he has a number of times, to a very apt illustration in his own family where he sent someone down to Johns Hopkins, brought him down and the member of his family was operated on by some other physician than the one they anticipated, I believe.

That brings to my mind an illustration—perhaps I shouldn't mention the individual's name, but I think I shall at this point. It happens I was a schoolmate of Dr. Walter Dandy of Johns Hopkins University, who died a year or so ago. He was an eminent brain surgeon.

If I had gone to someone under Government control, National Government control, and the authority there should have said, "Now you want to go either to Dr. Dandy or to Dr. William Smith out in Los Angeles," I would have selected Dr. Dandy because I knew Dr. Dandy and I would have preferred to have the ultimate right of choice, and I might make a mistake, but I believe I would like to have that power.

Now I think this bill, S. 1320, recognizes that, and I think it has made some effort to try to approach that. I am very doubtful as to whether it has succeeded in the approach to it, and I am greatly interested in Dr. Shearon's discussion of it here this morning.

I have known right along of her views on this, and this language I read from section 203 where it would sound like the individual may freely select the physician and may change the selection—there is a proviso, however, at the bottom of page 9,

> That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual.

Now I notice in part B, to which reference is made, that we come into this capitation system. That is on page 20, section 218. There is a provision that:

> Agreements for the furnishing of medical or dental services (other than specialists services) as benefits under this title shall provide for payment—

on one of four different bases, and the second one of those bases—these are optional, as I understand it—is—

> on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list.

Now it seems to me that obviously there is contemplated in this bill at least the possibility of a per capita basis being employed, and that, by the way, is left to each health service area under the terms of the bill

> as the majority of the medical practitioners or of the dental practitioners, respectively, under agreement to furnish such services shall elect.

If you do have a per capita basis, it would appear to me there is a restriction on the right of choice because if there is allotted—my suppositious friends that I mentioned—Dr. Johnson and Dr. Williams—there is allotted 1,500 to Dr. Johnson and 1,500 to Dr. Williams, and Dr. Johnson's panel is filled by the time I get around to the post office to sign up; I want him; he is the best physician in town, and everybody realizes it, everybody rushes to him.

Obviously I am precluded in making my choice of Dr. Johnson because I got there too late and therefore there is that restriction of choice inherent in this per capita system.

I am coming to the point I think you have in mind, Senator. You would say—perhaps I am not correct——

Senator MURRAY. I think we have discussed this before, many times before in this committee during the last several years.

Senator DONNELL. Yes; I am just sort of reviewing it in my own mind. I anticipate, Senator Murray, you will say that the same restriction exists today, because if you got to Dr. Johnson and he had more patients than he could take, he wouldn't take you.

Senator MURRAY. He would raise his fees and that would eliminate you.

Senator DONNELL. Well, I don't believe he would do that, generally speaking. I think doctors, generally speaking, are fair in their fees, and I think you think so, too.

Senator MURRAY. I think so. I have paid them many thousands of dollars and have never complained about them, and they all think that I am all right.

Senator DONNELL. Yes; and I have no doubt the Senator has been reasonable. I want to take this opportunity—this isn't just flattery, I don't mean it that way, but Senator Murray has been so nice in all these hearings, he and I had one little clash for about 2 minutes, and I think I was the fellow to blame. With the exception of that, I don't remember anything that was even remotely in the nature of any clash between us.

Senator MURRAY. That's right.

Senator DONNELL. I want to express my gratitude at this time and admiration for the Senator in the very kindly way in which he has dealt with the controversial subject here and his numerous kind applications to myself.

Senator MURRAY. That is very nice of you, Doctor.

Senator DONNELL. I want to express further appreciation that he has given to me out of the diploma mill here a free medical degree or at least a Ph. D. [Laughter.]

Now just a moment here, if I may, I think notwithstanding the answer that I anticipated Senator Murray would make to my point, that after all under the present system Dr. Johnson could decide for himself whether or not he has got up to his limit, whether he could stretch it just one more and take me in, but under this per capita system I think that would exist, if he had 1,500, without somebody, some official giving him a consent, he couldn't add me on.

Maybe I am wrong on that. If I am, I would like to be corrected. The point that I am making is—I am not going to take too much time because I am not the witness—it seems to me, although this bill, S. 1320, obviously recognizes the great importance of the right of free choice by the patient and emphasizes it in the respects I have indicated in two separate places, yet it provides for a per capita basis which obviously would not only limit in some cases at any rate the right of free choice, but would make necessary the exercise of what right of free choice there is at a time when perhaps the patient-to-be didn't ever anticipate what his troubles were going to be.

He might have thought he was going to have palpitation of the heart when he went down and registered for Dr. Johnson. He would have selected Dr. Williams, if he had thought he was going to have that particular trouble.

It seems to me that generally outlines the broad principles that to my mind are, of course, what Dr. Shearon has been saying here about this restriction of choice. I ask your pardon for taking so much time.

Senator MURRAY. I just want to make a single observation. It seems to me that these technicalities that we are talking about could easily be handled in each of the local communities. In the first place, the doctors will determine the number that will go on the doctor's list on a per capita basis. It seems to me that all of those things could be very easily adjusted, and if he is up to his limit and there is another person that wants to avail himself of his service, it would seem to me that that could be very easily handled by allowing the doctor to take the extra patient. There wouldn't be anything difficult about that.

It reminds me of some of the technicalities in the law. I remember a case out in Montana once where a corporation was holding a meeting of their directors and the law required that they should have a certain number to form a quorum. Well, about 2 o'clock in the morning they wanted to adjourn but they didn't have a quorum there, and they sat up for an hour or two waiting to get one of the members back so they could adjourn.

Of course that is all nonsense. It seems to me that these things are matters that can be very easily handled if they want to handle them on an intelligent and sensible basis by local grass-roots administration.

Senator DONNELL. Senator, I haven't mentioned the State of Missouri for a long time in these hearings, and I think you give me an opportunity right now. In my State I think the law is any of them, even less than a quorum, can adjourn.

Senator MURRAY. That is absolutely true, but they got all balled up about the technicalities of the thing by trying to construe the language of the bylaws too strictly and they lost 2 or 3 hours' sleep.

Senator DONNELL. That reminds me of the lodge of a certain fraternal order in our State. The record shows I think it opened some 20 or 25 years ago and hasn't closed yet. [Laughter.]

All right, Doctor, we have got off on some digressions here. You go ahead. Now Senator Smith has arrived at this time.

(Senator Smith took the chair.)

Dr. SHEARON. I just want to say one word more about that hypothetical list. Of course there would be a time when you would have to come to the end of the one more and one more that you could add on. You might get dispensation to make it 1,501, but you couldn't go on making it 1,521, and 1,551, and so on, if you are going to have a limit; and I might say that that limit has all been thought out by the Government people already. They have set it at 1,250. It has all been written up.

The difference between the way it is now and the way it would be then is that you go to a doctor now and if he isn't too busy he can say, "I will take you on," even though he may be a very busy doctor. Now when he has his capitation system he has his panel filled. He may be sitting in his office idle, perchance, but he has to go through the formality of taking you on the list, and so forth, so that he can't make a decision at that particular moment—when he is sitting there idle—to give you the service you need.

To me it is the cumbersomeness of the administration that doesn't show up in the beginning, and yet it is these details—you say you can work them out locally, but a great many of these things you have to have on the Federal level.

If you have 10 billion dollars in the Federal health kitty and it has to last 1 year and you have so many doctors and so many persons, you have to divide that up when it comes to so much per person per year, and you have to see that that money stretches out to do all the things you are going to have done with it, and you have got to do a great deal of this at the Federal level because the taxes are collected and are put in the Federal trust fund, not in the State trust funds, and then the money is divided out through the States from this Federal trust fund, and so on. I think you can begin to see some of the administrative difficulties.

Now answering your question a minute ago—I don't recall what page it was on—you asked me the name of the officer that would pass on disputed cases. That is on page 10, just beyond where you were reading, Senator, on line 13. It refers there to "the administrative medical officer." He shows up in a good many places.

Senator DONNELL. What line?

Dr. SHEARON. That's on page 10, line 13. You see, in case the medical officer—in other words, that medical officer refers a patient for services, I assume that would be a case of a recalcitrant patient who didn't do as he had been told, then the medical officer could refer him.

That section there also states about your getting a specialist when the insurance doctor you have, on whose list your name appears, says you can have the specialist. On that matter of deciding about whom you are going to have, supposing you are on an insurance doctor's panel. He is a general practitioner. That is what the panel system refers to.

He might not be a very good man to tell you who would be the best specialist to go to in a serious illness. He might not even himself be sufficiently aware of your condition. You might have cancer and he might not be alert enough. That is one of the criticisms that has been made, that the general practitioner at the present time is not trained to recognize incipient cancer. He may say, "You don't have cancer; I don't see any signs of it. I don't see any reason for you to go to a specialist."

When you pick that specialist to go to you would not necessarily go to a number of other general practitioners for advice. You might check, say, with the county or the State medical society. You might refer to some other specialist. There would be a number of things that you might do besides going to a general practitioner to ask advice about who was the best specialist in the field.

Senator DONNELL. Well, this administrative medical officer might not be able to decide whether or not it was wise for the desire of the patient to be carried into effect without himself making physical examinations of the patient. Isn't that right?

Dr. SHEARON. I would say that would be decidedly right, and furthermore, I would be very suspicious of an administrative medical officer who might never have practiced medicine. He would be a man who had gone into the administrative field. We have thousands of doctors who have never practiced medicine, and I don't think they would be very competent to decide on whether or not a person should have a specialist.

Those are serious matters, matters of life and death. It isn't just fooling around with something immaterial.

Well, anyway, that answers that question.

If the doctor of a patient's choice lived in an adjoining service area, the insured person would be able to have that particular doctor only by paying privately for his services in addition to paying social security taxes and increased income taxes.

We have said that they would be compelled as a rule to go to a doctor in their own service area for administrative reasons and to save the insurance funds. The insured person would be able to have that particular doctor only by paying privately for his services. In time, insured persons would be compelled to go to doctors at public-health centers or clinics, for it is proposed to compel physicians to practice in groups at such public-health centers in order to save the insurance funds.

In other words, if you happened to like the doctor that lived in the next service area, you might have difficulty in getting that doctor.

Senator DONNELL. Well, if that doctor in a next service area was on a per capita basis he might not be free to permit his services to be engaged.

Dr. SHEARON. That's right. I am trying to illustrate just a few of the perhaps easiest things to understand about the complexity of compulsory sickness insurance, a few of the administrative details. Some of the witnesses have said, "We do not understand the details. We will leave that to Congress." Congress not having too much information—Senator Donnell, I am sure you do not know the details of compulsory sickness insurance, you would say if we were going to have such a bill, "I would leave it to the experts." They are in the Government departments, so the public leaves it to Congress and the Congress to the Government departments.

Senator DONNELL. That is on the basis of your thought at least in part that the regulations are of more practical importance than the legislation.

Dr. SHEARON. That's right, they are much more voluminous than the basic laws. In a single sentence in the basic law you could say that the administrator of this law is authorized to write rules and regulations.

Senator DONNELL. You wouldn't realize the implications and results that flow from that power.

Dr. SHEARON. That's correct; and then you would get that 1,300-page book or thereabouts.

In time, insured persons would be compelled to go to doctors at public-health centers or clinics, for it is proposed to compel physicians to practice in groups at such public-health centers in order to save the insurance funds.

Now this isn't coming about in the beginning, but I can assure you that it is entirely in the picture and the planning, and part of the reason, part of the argument for compulsory insurance is that the Government is going to organize services, and in organizing them it will be more advantageous to put the doctors in groups and most advantageous to put them in groups in public-health clinics or other public centers where they will all work together as a group, and you go to that center and you get someone in that group. That is in the thinking and the planning, and should be realized before the enactment of any legislation.

Thus, such free choice as insured persons would have would exist at the moment of entry into the system. It wouldn't be so very free even at that moment. Thereafter they would be able to change doctors with difficulty and would probably be compelled to wait until the end of a quarter. By that time, of course, a patient might be dead, out of his troubles, so far as worrying about changing, at any rate.

I think this is a serious thing. We don't see it in advance, the little paragraphs and rules and regulations that say you may change your doctor at the end of a quarter. When you are well you don't think about it, but when you want to change in the middle of the night, you don't want to be held up by Government regulation.

Of course, I think the other side would be "If there is an emergency we do so and so." Having had a lot of experience in trying to get things done on an emergency basis when it involves the Federal or State and local governments, unless you are going to have 24-hour forces and so forth to get emergencies handled, Ithink you might have a great deal of difficulty.

Now coming to my next section, "Freedom of Choice To Be Abolished," that there is really no intention of letting people have free choice of a doctor is indicated by the attempt to decry freedom of choice as being a matter of no importance. The International Labour Organization which has laid down the principles on which S. 1320 was drafted, states, and I quote:

> The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem.

I think that that is extremely important. I am a little horrified to see I haven't the citation here. I have it in one of my booklets.

Senator DONNELL. Will you insert that and give it to the reporter later, Doctor, the specific citation on that?

Dr. SHEARON. Yes, I can easily find it because I have the citation in one of my documents here. I think it was in 1944 principles.

Senator DONNELL. Just supply that to the reporter, please.

Dr. SHEARON. I will be very glad to furnish that. I am almost certain it is in the 1944 principles, but I won't take the time to look it up.

(Subsequently Dr. Shearon submitted the following citation: ILO Report on Social Security Principles and Problems Arising Out of the War, Rept. IV (1), Montreal, 1944, p. 83.)

Carl Malmberg of the Democratic National Committee, former ghost writer for Dr. Mountin of the Public Health Service and former clerk for one of the subcommittees of the Committee on Education and Labor, states in his book "140 Million Patients"—Have you seen that, Senator? He states:

> Freedom of choice and personal relationship between physician and patient play not the slightest part in much of the very best medical care received in this country.

Senator DONNELL. What page is that?

Dr. SHEARON. I had reason for not putting all of these citations in because I had them in these documents here.

Senator DONNELL. Would you at a subsequent hearing give the reporter the page reference on that?

Dr. SHEARON. I should have done that, as a matter of fact, even though I had that quoted in my supporting documents.

Senator DONNELL. When was that written?

Dr. SHEARON. It just now came off the press. It is a document very strongly in favor of compulsion, and the latter part of the book is in support of S. 1320.

Senator DONNELL. Who is the publisher, the publishing house?

Dr. SHEARON. Reynal & Hitchcock, New York, *140 Million Patients*, by Carl Malmberg. That was in 1947. It is 242 pages long.

Senator DONNELL. Does he discuss in that book the proposed legislation in S. 1320?

Dr. SHEARON. Yes, this particular bill and also S. 1050, and so on.

Senator DONNELL. Is he favorable to those?

Dr. SHEARON. Very favorable. It is a document, shall we say, strongly in support of S. 1320.

Senator DONNELL. Is Mr. Malmberg a doctor, do you know?

Dr. SHEARON. No. I think he has an A. B. degree. I don't think he has any more than that. He had a clerical job at the Public Health Service when I was there, and used to do the ghost writing for Dr. Mountin.

Senator DONNELL. What is he doing now?

Dr. SHEARON. I think his interest is in journalism, and I believe the last time I checked very recently he was still with the Democratic National Committee. He went there after he left this committee. He may have changed very recently.

Senator MURRAY. Are you sure he was with the National Committee?

Dr. SHEARON. I am not sure. I say the last time I checked he was with the Democratic National Committee. He may have left very recently.

Senator MURRAY. I didn't know he was connected with them at any time.

Dr. SHEARON. Oh, yes; he did a good deal of writing. He is a facile writer and presents his subject very appealingly. I do not think that it is as accurate as it is appealing.

Mr. Malmberg after this statement then cites the case of persons going to the Mayo Clinic and to similar clinics. His statements are misleading in two respects. In the first place, a person goes to one of the great diagnostic or treatment clinics not for the day-by-day services of a family physician but for specialist diagnosis or treatment for cancer, diseases of the heart, or other serious conditions.

Furthermore, even at these great central clinics it is possible to select a particular surgeon, internist, or other specialist if one so desires. The main point to bear in mind here, however, is that the general practitioners who are to be forced into the capitation system are not the physicians and surgeons found at the Mayo Clinic or at similar clinics.

Senator DONNELL. May I see the book?

Dr. SHEARON. Yes; I have the citation this time. I didn't want to overload this particular testimony with citations. That's on page 186.

Now I feel that a statement like that going out to the public in a popular book, with copies and excerpts being taken from it and used for publicity and so on, all definitely designed to favor a certain piece of legislation is intentionally deceptive. When he says that the bill does nothing to abridge free choice and personal relationships, it isn't true. It is misleading, and I am wondering if Carl Malmberg didn't know better than that. I think he did.

Senator DONNELL. You say that quotation, "Freedom of choice and personal relationship," is found on page 185 of this book by Mr. Malmberg?

Dr. SHEARON. Yes; that's right. It's on the page preceding the one where he says there is nothing to abridge. Now that is extremely misleading. The only point that I want to make is that the public should know and Congress should know what is involved in the legislation. Then if you like it, that's well and good. But I have talked to a great many persons. They ask, "Oh, is that the way it would work?" They do not like it, and I don't think that the facts have been brought out.

That Federal officials have the fullest intention of changing completely the present form of medical practice is indicated in a report submitted to this committee in 1946 entitled, "Medical Care Insurance, a Social Insurance Program for Personal Health Services," prepared by I. S. Falk, who was largely responsible for S. 1606 of the Seventy-ninth Congress and S. 1320 which we are now considering. In regard to the methods of paying physicians he repeatedly indicates that the Government would use the capitation method or a full-time salaried service rather than the fee-for-service.

Senator DONNELL. You mean Mr. Falk?

Dr. SHEARON. Mr. Falk does; yes.

Senator DONNELL. All right.

Dr. SHEARON. I might say this is the medical insurance pamphlet (indicating) which was a report *to* the committee, but not *from* the committee. I think you did not vote on this report, but I think the public would think it was a report from the committee.

Senator DONNELL. Let the record show that this is a report marked on the front, "Seventy-ninth Congress, Second Session, Senate Committee Print No. 5, Medical Care Insurance, a Social Insurance Program for Personal Health Services, Report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate, July 8, 1946, printed for the use of the Committee on Education and Labor, United States Government Printing Office, Washington: 1946."

I judge it comes as a result of a letter which is set forth early in the preceding report from Senator Murray to Mr. Altmeyer, chairman of the Social Security Board, and that Mr. Altmeyer in his letter of April 22, 1946, which likewise appears, says:

> The report was prepared by Mr. I. S. Falk, director of the Bureau of Research and Statistics in the Social Security Board, with the assistance of the Bureau Staff.

Note also that Mr. Altmeyer says:

> However, this study does not necessarily express the final conclusions, either of the Bureau or of the Social Security Board, on policy questions."

Do you know anything about the circulation of this particular document, Senate Committee Print No. 5, Doctor?

Dr. SHEARON. No; I do not. It would be interesting to know, because it has gone out all over the country, I understand, and we have had witnesses coming in and quoting from it as though—and I am sure that they thought—it was a report from the committee with the approval of the committee.

Senator DONNELL. The names of the committee are all set forth on the inside flyleaf. I don't mean to imply by that any misrepresentation.

Dr. SHEARON. I think the way it comes out it gives that impression.

Senator SMITH. I may be mistaken in my recollection, but I don't recall having seen this report or having had it come before the attention of our committee.

Dr. SHEARON. I don't think there was any voting.

Senator SMITH. I was on the subcommittee at that time investigating these matters. I don't recall our discussing it on the subcommitee. It is apparently a report from the Bureau of Research and Statistics of the Social Security Board addressed to our committee, but what I am concerned with about it is that if this was circulated widely, it would look as though it had the endorsement of the committee.

Dr. SHEARON. I think it could be thought——

Senator SMITH. I think we want to be careful about that practice.

Senator MURRAY. Well, the document on its face indicates what it is. It is a report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor——

Senator SMITH. That's right.

Senator MURRAY. United States Senate, and it shows on the first page that it came in response to a letter from me asking Mr. Altmeyer to prepare this study. It was sent to every member of the committee, and I assume that it contains information which would be very valuable for them to read and to understand.

Senator DONNELL. I am wondering if Senator Murray has any knowledge as to the number of copies of this Senate Committee Print No. 5 that was distributed.

Senator MURRAY. I think there were 2,000 printed altogether.

Senator DONNELL. Does the Senator know whether they were distributed to the public?

Senator MURRAY. I don't know. We did have some people write out expressing interest in the subject and we did supply copies to them.

Senator DONNELL. I think Senator Murray is quite correct. It shows on its face what it is. However, I do think this is entirely possible, that coming out as it does under the eagle imprint here of the United States Government Printing Office, it has a certain tendency——

Senator MURRAY. That is a customary practice in all the different committees of the United States Senate.

Senator DONNELL. I am not criticizing at all, Senator. I just think a casual reader would at least think that it had the right to the presumption of correctness, because it was prepared by the Bureau of Research and Statistics, having been published as it is by the United States Government Printing Office. I quite thoroughly agree that if the flyleaf were read by the reader he would observe it was a report from that Bureau to the committee.

Senator MURRAY. Mr. Altmeyer indicates that it isn't the final thinking of the Department.

Senator DONNELL. I think that is true.

Senator SMITH. I want to add also—I am not critical of that, but I think it is in the form we frequently have reports made to committees. It might imply we all agreed to all the contents. A person should not be misled if he reads carefully what is said.

Dr. SHEARON. I might add, on the circulation question, of course, if you wrote into the Social Security Board for information on medical programs, you got a copy of this—and I don't think that they also distributed at the same time a copy of a statement about S. 545, the other approach. I got a large kit from the Social Security Board when I myself wrote directly to them, and it was all along the lines of compulsion, and of course that question has been raised by the Investigating Committee.

Senator DONNELL. I think it would be appropriate at this time to read into the record the introductory note over the name of Senator Murray, chairman of the Committee on Education and Labor, July 1946, which appears at page xi of this Senate Committee Print No. 5. It says:

> There is no longer any serious question as to the need for measures to relieve American families of the burden of medical costs and to assure the Nation-wide availability of adequate medical care. Differences of opinion now relate to the method of achieving that goal. In his message of November 19, 1945, to the Congress, President Truman recommended solving the problem through expansion of our present social insurance system. In considering that recommendation, and alternative proposals, the American people should have as clear a picture as possible of what a national medical care insurance program would mean to persons receiving and to practitioners and agencies furnishing medical services.
>
> It came to my attention that the Bureau of Research and Statistics of the Social Security Board was preparing for the use of the Board and members of its staff, a report which summarized their studies of a national medical care insurance system for this country. In view of the potential value of this study to the members of the Senate Committee on Education and Labor and to others who are concerned with health problems, I asked the chairman of the Social Security Board to make the report available to our committee for immediate publication.
>
> The report deals with problems of the utmost importance to the American people. It provides detailed information, and an analysis and estimates not hitherto generally available.
>
> This report is made public in the belief that it offers to members of Congress, to members of the medical and related professions, and to citizens generally, information which will be of value to them in reaching their own decisions on a question of public policy which is of fundamental importance to the health of our nation.

Now of course that is in this document, which is Senate Committee Print No. 5, printed for the use of the Committee on Education and Labor, and yet evidently the report is, as Senator Murray said in this introductory note, made public in the belief that it offers to members of Congress—not only to members of the committee—to members of the medical and related professions and to citizens generally, information which will be of value to them in reaching their own decision on a question of public policy which is of fundamental importance to the health of our Nation.

I would respectfully request, Mr. Chairman, that while it is not necessary at all to reprint this document, that it be considered in evidence in the hearings in this case and that a copy be procured by our clerk and filed with the proceedings for further reference by the members of the committee.

Senator SMITH. I think that is an appropriate suggestion. We will have it available for consideration when we are discussing the bill. It might be noted too that that went out at the time when some controversial measures were being considered for this legislation, and it might be considered by some as taking one side of the discussion without presenting the other side as well.

Senator DONNELL. Now, Doctor, will you proceed, please.

Dr. SHEARON. Mr. Chairman, could I have inserted at the proper place, in answer to your previous question where that quotation came from the International Labor Organization, I do have the volume here and I was correct in recalling that it appeared in the volume entitled, "Social Security, Principles and Problems Arising Out of the War, Part I, Principles," published in Montreal.

Senator SMITH. I want to announce now—we just heard the bell notifying us of the Senate session—we will adjourn today at 12 o'clock and the committee will meet tomorrow morning again at 10 o'clock to continue Dr. Shearon's testimony.

I want to state also, before it escapes my mind, that I have been advised that the Brookings Institution has just about completed its study of this subject, and I am going to ask, if there is no objection, that it be in the record—not the whole report; we have the report available, but—the conclusions of that study. If they are too long to insert, we will have our staff member make a general summary for inclusion in the record which I will submit to members of the subcommittee.

Senator DONNELL. Dr. Shearon, you were just giving us that citation when we interrupted you.

Dr. SHEARON. It was 1944. This is the quotation, p. 83. I have here on page 18 of my testimony in which the International Labor Organization in regard to this Principles in 1944—this is very recently—said:

> The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem.

Senator DONNELL. Does the United States representative concur in that?

Dr. SHEARON. I don't think he has permission to.

Senator DONNELL. What is that, a declaration of principle?

Dr. SHEARON. This is the principles, yes.

Senator DONNELL. Of the International Labor Organization?

Dr. SHEARON. Yes, that's right.

Senator DONNELL. Was it adopted or proposed?

Dr. SHEARON. It was proposed. It is under consideration.

Senator DONNELL. Was it adopted, do you know?

Dr. SHEARON. I don't believe so, no.

Senator DONNELL. Who proposed it, do you know?

Dr. SHEARON. The committee of the International Labor Organization. They met, however, the year before in Montreal when our representatives were present, and had a great deal to do with the thinking, and I have the transcript of what transpired at that time. I have it on the table.

Senator SMITH. Doctor, may I interrupt you just a minute? I am not quite clear on this quotation that appears on page 18 of your remarks. Was that part of a report made to or by the ILO?

Dr. SHEARON. It is by the ILO.

Senator SMITH. By the ILO?

Dr. SHEARON. Yes.

Senator DONNELL. On something that was adopted or something that was proposed?

Dr. SHEARON. It is under discussion. It was proposed. I don't know what the vote is. The ILO is all upset at this minute. One can't get much information out of them. I think Mr. Falk would know a good deal about that, more than I do.

Senator DONNELL. Well, I observe here—this appears in an article entitled, "Quality of Service," page 83, in which it says:

> The right of the patient to choose his doctor in each case of illness is therefore no longer compatible with modern approach to the health problem. It is all the more dangerous to leave the beneficiary to make his own choice in each case if specialist treatment is available, as he cannot be expected to know what kind of special treatment his condition requires.

Dr. SHEARON. I didn't quote it all.

Senator DONNELL. No. It seems to me that that is a very comprehensive statement, and while it may well be that the patient isn't expertly qualified, I personally would like to have a little something to say about it myself, if I were the patient.

Now let's see. This is a document here. Let's see what it says at the outset here. It is marked "Part I, Principles," and it is Report IV (1), Twenty-sixth Session, Social Security, Principles and Problems Arising Out of the War. Now this that I have read here is not set out in these so-called "proposed recommendations."

Dr. SHEARON. They came after.

Senator DONNELL. They appear first on page 43 and following, I believe.

Dr. SHEARON. But the principles are later on.

Senator DONNELL. Yes. There are some later on, too.

Dr. SHEARON. This is description, really.

Senator DONNELL. I wonder, Doctor, if you could, between now and tomorrow, kindly indicate by some type of memorandum just what this is; whether it is something that was adopted; whether it was somebody's paper, or what it is?

It is a little difficult here to read this preface, which is several pages in length, and know whether or not this is some final action, or what it is. If you could just be kind enough to check on that and let us have the benefit of that in the continuation of your testimony tomorrow, it would be very helpful. Will you do that please, Doctor?

(Dr Shearon submitted the following memorandum:)

Declaration adopted by the International Labor Conference at its twenty-sixth session in Philadelphia on May 10, 1944. (See Official Bulletin of the ILO, Vol. XXVI, No. 1, June 1, 1944.) The General Conference of the ILO adopted a declaration of aims and purpose of the ILO and of the principles which should inspire the policy of its members. The United States is a member Nation. In this Declaration is this statement (loc. cit., pp. 2 and 3):

"The Conference recognizes the solemn obligation of the International Labor Organization to further among the nations of the world programs which will achieve:

"* * * (f) the extension of social-security measures to provide a basic income to all in need of such protection and comprehensive medical care."

The General Conference of the ILO further, on May 12, 1944, adopted a recommendation (No. 69) concerning medical care (loc. cit., p. 20 ff.). In that recommendation is included *inter alia*, the following statements:

"Whereas the availability of adequate medical care is an essential element in social security; and

"Whereas the International Labor Organization has promoted the development of medical care services, by (inter alla) the participation of the International Labor Office in an advisory capacity in the framing of social insurance schemes in a number of countries (including the United States) and by other measures; and

"Whereas some Members have not taken such steps as are within their competence to improve the health of the people by the extension of medical facilities, the development of public health programs, the spread of health education, and the improvement of nutrition and housing, although their need in that respect is greater, and it is highly desirable that such Members take all steps as soon as possible to reach the international minimum standards and to develop these standards; and

"Whereas it is now desirable to take further steps for the improvement and unification of medical care services, the extension of such services to all workers and their families, including rural populations and the self-employed, and the elimination of inequitable anomalies, without prejudice to the right of any beneficiary of the medical care service who so desires to arrange privately at his own expense for medical care; and

"Whereas the formulation of certain general principles which should be followed by Members of the Organization in developing their medical-care services along these lines will contribute to this end:

"The Conference recommends the Members of the Organization to apply the following principles, as rapidly as national conditions allow, in developing their medical-care services with a view to the implementation of the fifth principle of the Atlantic Charter, and to report to the International Labor Office, as requested by the Governing Body, concerning the measures taken to give effect to these principles."

The detailed Recommendation comprises 114 principles regarding a medical-care service.

This declaration and the several recommendations and resolutions adopted by the International Labor Conference were referred to the President of the United States. He, in turn, referred them to the Congress for its information and as a guide in drafting future legislation relating to social security and provision of medical care by the Government. (See message from the President of the United States to the House of Representatives, 78th Cong. 2d sess., Doc. 261, House of Representatives, May 29, 1944.) The declaration of principles was incorporated in the new charter of the ILO which was approved by Congress in 1948.

Dr. SHEARON. Yes, I will be very happy to. It does show the thinking that is in mind, and I am sure that the people in this country don't realize that.

Senator DONNELL. What page is that?

Dr. SHEARON. Page 83.

Senator DONNELL. All right. Now Doctor, we have about 9 minutes more here. You just go ahead, please.

Dr. Shearon. I am referring to this report on Medical Care Insurance that was prepared by Mr. Falk as the report to the committee and from the Bureau of Research and Statistics.

Senator Donnell. That is the one that is marked up at the top——

Dr. Shearon. Senate Committee Print No. 5, Seventy-ninth Congress, second session.

Senator Donnell. All right.

Dr. Shearon. In regard to the methods of paying physicians he repeatedly indicates that the Government would use the capitation method or a full-time salaried service rather than the fee-for-service.

Senator Donnell. That is, you mean he repeatedly indicates that in the report?

Dr. Shearon. In the volume of the text, yes, and administratively he is entirely correct in that. That is what you would have to do if you had this kind of system.

In computing administrative costs and in giving illustrations of the way things would work, he refers to the capitation method as though it were the desirable one and the one the medical profession would choose.

Michael M. Davis, leading nongovernmental lobbyist for the nationalization of medicine, also decries the fee-for-service method of payment, stating that it

> is most open to abuse by patients and physicians and is the most costly to administer.

That is the fee-for-service.

> Adequate control of the services requires fiscal and professional supervision which is expensive and often vexatious.

And that is true, also.

> The promotion of quality and of prevention is difficult. The use of the fee-for-service method should therefore be discouraged, except for specialist services under certain conditions.

That is in this volume that was published by the Committee of Research in Medical Economics, of which Mr. Michael M. Davis is the chairman, and which was approved by this group of 29 persons, "Principles of a Nation-wide Health Program, Report of the Health Program Conference."

Senator Donnell. Of whom Mr. Falk is one?

Dr. Shearon. Of whom Mr. Falk is one, and these other Government officials.

Senator Donnell. Now this fee basis that Mr. Davis states should be discouraged——

Dr. Shearon. Fee-for-service?

Senator Donnell. Yes. That is the plan that is set forth at page 20 of S. 1320 under section 218 as follows:

> On the basis of fees for services rendered as benefits, according to a fee schedule.

Dr. Shearon. That is correct.

Senator DONNELL. In other words, section 218 gives four different methods that might be followed for payment for services. One is on the basis of fees for services, and that is the one that Mr. Davis says should be discouraged.

Dr. SHEARON. That is right.

Senator DONNELL. The next choice is on a per capita basis. That is the one, as I undertsand it—it is true—that Mr. Falk repeatedly indicates would be used by the Government.

Then the salary basis is third. I don't know what position is taken by these gentlemen on that.

The fourth option is, "Or such combinations or modifications of these bases, including separate provision for travel and related expenses, as may be approved by the State agency." That is right, isn't it?

Dr. SHEARON. Yes, Senator.

Now Dr. Ernst P. Boas, another lobbyist for the nationalization of medicine, has stated:

> Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained.

Senator DONNELL. That is the same Ernst Boas that testified here some time back, and we have had previously mentioned in the testimony. Is that right?

Dr. SHEARON. That is correct, and he is the chairman of the lobbying group, the Physicians Forum. I don't know if they registered as lobbyists. They had not the last time I checked, but they may have since then.

It is perfectly apparent that the Federal Security officials who drafted S. 1320 have not the slightest intention of leaving the form of medical practice as it is now. Indeed, they insist that medical services must be organized and that such organization will be furthered if family doctors are paid on a capitation basis or on a salary basis.

In the light of these statements, I submit that it is a gross misrepresentation of the methods of national compulsory medical care insurance to state or to imply that the only difference that this legislation would make is that patients would not pay for services at the time such services are rendered.

Senator DONNELL. Doctor, let me ask you this. It is just 4 minutes to 12. Would you prefer to start on the next subject, "Is Panel Medicine America's Choice?" now, or do you think it would be better to wait until tomorrow morning?

Dr. SHEARON. Yes, it would be much better.

Senator MURRAY. Mr. Chairman, in connection with this subject of publishing articles and statements for the benefit of the committee, I want to call attention to the fact that we published also committee print No. 2 entitled, "National Health Act of 1945," which contains statements by the American Medical Association explaining their attitude towards this legislation, also editorials from the Journal of American Medical Association, "The American Medical Association and Medical Care," by Dr. Louis H. Bauer, "New Medical Care Programs and the American Medical Association," and also a statement by the Physicians Forum endorsing President Truman's message on National health insurance, and other things, including statements opposing health insurance by the National Physicians Committee for the extension of medical service, and articles which they got out in editorials, showing that we were giving both sides of the controversy to the Members of Congress and to the public.

Senator DONNELL. Might I mention at this point, Mr. Chairman, that this Senate committee print No. 2, which was issued December 4, 1945, is entitled, "National Health Act of 1945, Report to the Committee on Education and Labor, relating to the bill (S. 1606) to Provide for a National Health Program"—that is the Wagner-Murray-Dingell bill—and that the letter of transmittal from Senator Murray to the members of the Committee on Education and Labor reads as follows, dated December 4, 1945:

> I am transmitting herewith for the information of members of the committee a number of documents giving the views of professional organizations and individual members of the medical profession advocating and opposing health insurance. Some of these documents relate to the health-insurance proposals of S. 1050 and H. R. 4730—the National Health Act of 1945—are identical with the health provisions of the earlier bills these documents are still relevant to the health insurance bill now pending before this committee.
>
> As more documents become available they will be transmitted to the members of the committee for their information.
>
> Sincerely yours,
>
> JAMES E. MURRAY, *Chairman.*

I don't know, Senator, whether there are any conclusions drawn in this document or not.

Senator MURRAY. You will find it is largely given over to the opposition to the bill, and has a statement in the back part of it by Dr. Clark.

Senator DONNELL. Mr. Chairman, I would like to move that just as in the case of Senate Committee Print No. 5, so with Senate Committee No. 2, we have a copy procured and filed with our records in connection with this hearing.

The Chairman in an aside made a suggestion which I think is very excellent, if he would be kind enough to repeat it at this moment.

Senator SMITH. Senator Donnell, it would seem to me that certain of these documents were brought to our attention, and I think we might have filed with the committee for reference everything that has been published of this nature in the way of reports since these hearings began. I think Senator Murray would agree with me.

Senator MURRAY. Certainly. All of these are in the possession of the committee right now.

Senator SMITH. Then we will have a reference made to them in our records so we will have them before us.

Senator DONNELL. I note in the one just mentioned, No. 2, the letter of transmittal from Senator Murray, there is no mention of the circulation of this to the members of the medical profession or related professions or the public generally, there being some such statement, however, in the letter preceding No. 5, which I read a little while ago. I think that is correct.

Senator MURRAY. That is right, Senator.

Senator SMITH. Well, the committee will stand adjourned until tomorrow morning at 10 o'clock. Dr. Shearon will then continue her testimony.

Senator DONNELL. Senator Murray states that print No. 2 did have circulation among the medical profession.

(Whereupon, at 12 o'clock noon the committee adjourned, to meet at 10 a. m. on February 5, 1948.)

NATIONAL HEALTH PROGRAM

THURSDAY, FEBRUARY 5, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee hearing room, Capitol Building, Senator Forrest C. Donnell presiding.

Present: Senators Donnell (presiding) and Murray.

Senator Donnell. The committee will be in order. Senator Smith is ill this morning and has asked that I proceed with the hearing in his absence, which will proceed, of course, as if he were present.

I think Senator Murray has a matter that he desires to present to the committee. Pardon me, Senator, but before you do that might I put this wire into the record? There has been handed to me this morning by Dr. Joseph S. Lawrence, who is representing the American Medical Association—that is correct, is it not, Dr. Lawrence, you are appearing in that capacity?

Dr. Lawrence. Yes.

Senator Donnell. Dr. Lawrence has handed me a telegraphic message received in Washington February 4, 1948, addressed to Dr. Joseph S. Lawrence, signed by A. C. Callister, M. D., chairman of the Utah State Board of Health. I have shown this telegraphic message to Senator Murray, and it is agreeable to him that it be inserted in the record:

Jos. S. Lawrence, M. D.,
Washington Office, A. M. A., 1302 18th St. NW.,
Washington, D. C.

I have just had referred to me a letter by Dr. W. W. Bigelow, acting State Health Commissioner, in which he indicated to Senator Smith that the sentiments of the Board of Health of the State of Utah indicated a preference for S. 1320 compulsory tax plan, rather than S. 545.

I wish to call your attention to the fact that Dr. Bigelow got the two plans confused and the sentiment of the Board of Health of the State of Utah is definitely opposed to S. 1320, the compulsory tax plan and indicates a preference, if any legislation of this type is to be acted upon, for S. 545 plan.

I am taking these steps to correct the error made so that this information may come promptly to the attention of the committee conducting the hearings.

A. C. Callister, M. D.,
Chairman Utah State Board of Health.

Senator Murray. Mr. Chairman, yesterday I introduced a statement by Mr. Al Goldsmith. I would like to temporarily withdraw that for further study, reserving the right to introduce it later on, after I have had further opportunity to investigate.

Senator DONNELL. That will be done. And may I ask the Senator if there is objection on his part to having the stenographic company which is making the report of these hearings directed not to issue to anyone that letter until after you have approved it? That is, both the letter of transmittal and the letter which was so transmitted.

Senator MURRAY. Yes, sir. Now, Mr. Chairman, yesterday I asked Mr. Falk to comment on the testimony being given by the witness who is now in the chair, and I have a letter from him this morning in which he takes issue with some of the statements which are being made, claiming that they are not in accordance with the position he has taken, or the position of the Social Security Administration, and it seems to me that while this subject is fresh in our minds it might be well if we could have Mr. Falk appear and testify with reference to some of these points, so that we could have it cleared up as we go along, and I make that request at this time.

Senator DONNELL. I think that is a proper request. This matter arose just a few minutes ago, and may I say that Dr. Shearon was not advised of it until your announcement, Senator, so far as I know. I think it might be well to have the letter read into the record, and then we will hear Dr. Falk.

Senator MURRAY. That will be entirely satisfactory. The letter dated February 4, 1948, addressed to me, reads as follows:

DEAR SENATOR MURRAY. In response to your request, I want to repeat that at the hearings this morning Mrs. Marjorie Shearon misrepresented the content of one of our publications and gave the subcommittee other misinformation. I cite three specific items:

1. Mrs. Shearon founded a major portion of her testimony on the alleged undesirable consequences of remunerating physicians by capitation payments (*Testimony*, page 16 and following), and then stated (*Testimony*, p. 19) that the capitation method and full-time salaried service are given preference over fee-for-service in the document prepared by us and printed by the Committee on Education and Labor (*Medical Care Insurance*, Committee Print No. 5, July 8, 1946).

The alleged bad consequences of capitation payments are, to say the least, grossly exaggerated.

Mrs. Shearon's statement about the preference expressed in our report is untrue, and I should be glad to have an opportunity to give the Subcommittee accurate information about that report and what we said in it bearing on methods of paying physicians.

2. Mrs. Shearon's testimony about the relation between the capitation method of payment and free choice of doctor completetly confused two separate matters: Change of doctor, and referral from a general practitioner to a specialist. It is my impression that the discussion of her testimony on this subject left the subcommittee members misinformed as to our views (and possibly also as to the pertinent provisions in S. 1320). I should be glad to clarify this subject for the subcommittee.

3. In connection with her testimony about rules and regulations, I understood Mrs. Shearon to say that I had already prepared rules and regulations for a health insurance system, and that she had a copy of the document. Since I have not prepared any such document, I should welcome an opportunity to challenge her statement before the subcommittee.

These three items concern specific points in today's testimony by Mrs. Shearon. I have noted many other misrepresentations and sources of possible confusion in her prepared testimony document, and I should be glad to have an opportunity to comment on some of them before the subcommittee—especially on items which are of a technical nature and therefore may not be fully appreciated by the Members.

With my respects, sincerely yours,

I. S. FALK, *Director*.

Senator DONNELL. Now, Mr. Falk, will you step forward and proceed with your statement? And I would suggest that Dr. Shearon take this chair up here, if you will, so I may have the benefit of any documents that she may have here bearing on this matter, and then after Dr. Falk has finished, Dr. Shearon, I take it, will be permitted to reply to whatever Dr. Falk has to say.

FURTHER STATEMENT OF I. S. FALK, DIRECTOR OF THE BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, WASHINGTON, D. C.

Mr. FALK. I appreciate very much, Senator, this opportunity to give you what I regard as useful information to the committee to indicate the way in which and the extent to which, on these particular items, our views and our statements in certain documents have been presented to the committee erroneously, and to be given the opportunity to avoid further misunderstanding on the part of those who have come before the committee.

The first of the three points I mentioned specifically in the letter to Senator Murray, referred to what I believe I do not exaggerate in calling misrepresentations of what we said in one of our documents. In Mrs. Shearon's prepared testimony, page 19, she says:

> That Federal officials have the fullest intention of changing completely the present form of medical practice is indicated in a report submitted to this committee in 1946 entitled "*Medical Care Insurance; a Social Insurance Program for Personal Health Services*," prepared by Mr. I. S. Falk, who was largely responsible for S. 1606 of the 79th Congress and S. 1320 which we are now considering. (6) In regard to the methods of paying physicians he repeatedly indicates that the Government would use the capitation method or a full-time salaried service rather than the fee-for-service. In computing administrative costs and in giving illustrations of the way things would work, he refers to the capitation method as though it were the desirable one and the one the medical profession would choose.

Again, on page 21 of her testimony, she says:

> The Social Security Administration plans are drawn for 5, 10, and 15 years hence. I refer here to the plans described in great detail in Senate Committee Print No. 5 of the Seventy-ninth Congress, second session, 1946, "*Medical Care Insurance*," by I. S. Falk.

Substantially the same testimony appears in the transcript of yesterday's hearings, and I will not take time to find the references. On page 750 of the stenographic transcript, near the bottom of the page, appears a paragraph in which Mrs. Shearon said—and I hesitate to read it, because upon casual inspection it appears to be verbatim what I have just read from the prepared testimony.

Senator DONNELL. What page is that?

Mr. FALK. Page 750. Following that statement the transcript says:

> Senator DONNELL. You mean Mr. Falk?
> Dr. SHEARON. Mr. Falk does, yes.
> Senator DONNELL. All right.

Then on page 762, the subject having been interrupted by exploration of some other point, and the testimony having resumed discussion of this document which is before us, Dr. Shearon—I am reading now——

> Dr. SHEARON (interposing). Senate Committee Print No. 5, 79th Congress, Second Session.
>
> Senator DONNELL. All right.
>
> Dr. SHEARON. In regard to the methods of paying physicians he repeatedly indicates that the Government would immediately use the capitation method or a full-time salaried service rather than the fee-for-service.
>
> Senator DONNELL. That is, you mean he repeatedly indicates that in the report?
>
> Dr. SHEARON. In the volume of the text, yes; and administratively he is entirely correct in that. That is what you would have to do if you had this kind of system.

Now, I cite these quotations and I believe that since I have taken the matter up and presented it, the members of the committee will recall the discussion. I thought this was a matter on which what I regard as misinformation should be corrected while it is fresh in your minds, because, as you will recall, a very substantial share of Dr. Shearon's testimony is concerned with that section which she has labeled Rules and Regulations. She has emphasized very extensively the importance of rules and regulations as against the basic statute, the role that rules and regulations might play in producing certain undesirable consequences of a compulsory health-insurance system. In respect to the discussion of rules and regulations, as you will recall, she places very heavy emphasis on the fact that whether a basic statute so provides, or Congress in enacting the statute so intends, the system would nevertheless come to be one operated on a capitation or full-salaried payment basis, and in that connection she made these statements which I have read and to which I have referred. Therefore, it seems to me to be very important for the record to be correct as to whether or not—if these dire consequences may result from the capitation method, which, as I have indicated in the letter to Senator Murray, I think are very grossly exaggerated, and I will be glad to discuss that with the members of the committee if you wish—I think it is important to ascertain whether or not, accepting for the moment these alleged dire consequences, we did or did not recommend or indicate repeatedly, as Mrs. Shearon says, a preference for that particular method of payment. Now, we might have, and yet we might not agree that those dire consequences would follow. But I am not addressing myself to that question at the moment. I am addressing myself merely to the question of fact whether we did or did not, in the documents which she discussed, indicate any preference for one method of paying doctors or another.

We have taken the position in our former testimony before this committee, when our representatives appeared before you, in our public documents and in private statements, that we believe, and we have believed for a long time, in certain cardinal principles which should be applied in this field.

First, free choice of the patient, in choosing the doctor or dentist or hospital, insofar as that is compatible with a second cardinal principle, the privilege of the physician or the dentist or other practitioner to accept or reject the patient.

We have also said, as a third cardinal principle, that the method by which practitioners or service-providing institutions are remunerated is one which, insofar as it does not affect the general finances of the system, the method of payment should be one, preferably, selected by those to whom the money would be paid. The amount of payment and the aggregate cost of the system are, of course, of very serious concern to the system itself and to those who finance it; but the method by which the amount of money is disbursed, the one by which you can give the largest measure of responsibility to those who are to be paid so as to assure that the method is best adapted to their purposes, their wishes, their needs, their method of practice. The method so chosen is the one to be desired. We have again and again expressed our views on that point. In accordance with those principles to which I refer we have, I believe, adhered to them strictly, and I propose to indicate\to the committee that as to the point I am speaking of, I and the members of my staff—when we prepared the document which was printed as committee print No. 5—adhered to those principles. Indeed, I may go further and say that in speaking about this, in general I believe I am correct in expressing the opinion not only of myself and members of my immediate staff but also of all the responsible officials of the Social Security Board, as it was formerly, now the Social Security Administration—all of the responsible officials of the Public Health Service and other branches of the Federal Security Agency, because on these points there has been very little, if any, important difference of opinion. As I say, I want to indicate to the committee what we did say in that document, as against what Mrs. Shearon alleged yesterday we said, and what she said in her prepared testimony presented here last week. If I may take a few minutes—and I will try to make this very brief before getting to the specific points—I think it will be of assistance to the members of the committee if I indicate what this document is.

Yesterday's discussion, I think, may have left you with some confusion. This is, as I said before, preliminary to the specific points, but if I am not off the beam I think you will find this interesting and valuable. Your record of the discussion yesterday indicates that this document was printed by and for the use of the committee. Let me tell you briefly about the background and how that came to pass.

This document was in preparation a long time before it was printed, years before it was printed—in this sense, not that the document specifically was in preparation over many years, but that the various drafts of this document were in preparation over a period of substantially 10 years, more or less. I will identify dates for you if they become of any consequence.

This document is primarily and substantially a summary of the analysis of a compulsory health-insurance system with respect to its costs. Over the years in which the Social Security Board, later the Social Security Administration, engaged in the study of social insurance for health protection, acting as a responsible body it, of course, undertook to examine the potential specifications of an insurance system. The Social Security Board never, to my knowledge, made a recommendation to the President or to the Congress or to any public group on a major question unless it had first considered carefully and explored responsively the potential consequences of that recommendation.

In the course of the studies in the health field, before the Social Security Board reached a conclusion and made a recommendation in its annual report to the President in favor of social insurance, it had studied very carefully what a social-insurance system in this country might be like, what its specifications might be, what its potential administrative organization could be, whether it was administratively feasible and manageable, and what its potential cost might be.

In the annual report and other documents in which the Board made its recommendations, it indicated briefly the approximate estimated cost. It did not give the details. The Board was on various occasions rather severely criticized by presumably responsible people for not having made public in some detail the basis of its estimates. Consequently the Board directed me to bring together and put in the form of a document that could be made public the data which we had accumulated over a period of many years on the specifications and costs of an insurance system, and which were basic to the Board's recommendations in favor of a health insurance system, and which were the basis of the Board's estimate of those costs. We had in our offices, in our files, hundreds, perhaps thousands, of memoranda and documents bearing on these cost studies. These were, of course, piecemeal and technically detailed documents which we had developed in the course of the study of this matter. They were themselves not suitable for any public presentation as a basis of the Board's estimate. Consequently, and by direction of the Board, we undertook to pull that material together in a single, consecutive, comprehensive document. The document which you have before you was the result of that work. It was our plan to publish that document as one of our own regular, technical documents.

Before the time when we completed that study Senator Murray, Senator Wagner, and others were being severely criticized because S. 1606, which had been introduced in the interim, did not contain financing provisions, as you will recall, and because the Senators had not presented with their bill any substantial explanation of the approximate cost estimate which was stated in a speech, which, if I recall correctly, was made by Senator Wagner on the day S. 1606 was introduced.

Time and again we received communications from Senator Wagner—I know that at second-hand, not first-hand—and time and time again I was personally told by Senator Murray that they had need for whatever cost data we had available, and that we might be able to furnish them, that would bear specifically on health insurance in general, or S. 1606 in particular. On every such occasion I informed Senator Murray of the work we had in preparation, and advised him that what we were doing did not bear specifically on S. 1606 or any other bill, but on a health-insurance program in general. I informed him on various occasions that, as to the cost of the particular bill, those estimates probably would not be available until the Board or the Agency would testify on the bill. I told him on various occasions that we did have in preparation a document on cost analysis of health insurance. On an occasion which I cannot identify now, Senator Murray asked me, when I told him that the document was approaching completion, whether that could be made available to the committee. I told him at the time we would be very glad to make it available to the committee, provided, however, it did not thereby become a confidential document of the committee, because we were under obligation to make the result of that study available publicly. Consequently, at the date which is identified in the document, Senator Murray knew that our study was not completed but was approaching completion, and he addressed a communication to Mr. Altmeyer, chairman of the board, requesting that that document be made available to the committee. Some further period of time elapsed, because we were slower in completing the document than we had hoped to be; but somewhat later Mr. Altmeyer transmitted the document to Senator Murray. Senator Murray arranged, as chairman of the Committee on Education and Labor, to have that document printed for the use of the committee, and by having it reprinted, as I understood it, having it available for distribution to others as well. As part of the agreement of that time, which I made with Mr. Charles Murray, who will undoubtedly recall the occasion, we were to be privileged to purchase reprints of that document, so that we might have them available for our own use. The printing and publishing of that document, I might say for the record, had been carried in our budget estimates for 2 or 3 years, the period during which this document was in preparation, and we had included its publication as one of our estimate items for our printing budget. By this arrangement, however, it was possible for the document to be made available promptly both to the committee and to us. When the document was printed by the committee, for the use of the committee and others, we purchased reprints.

Senator DONNELL. Do you remember how many copies you purchased?

Mr. FALK. Yes; my office informed me this morning that we purchased 5,000 reprints in 1946 at a cost of $612. We still have about 2,500 of them in our office. I might state in passing it has been said by Mrs. Shearon that the document has been widely distributed. I don't know how widely it was distributed by the Senate committee, but to indicate how widely it was distributed by us, I may state that our distribution was entirely a "request" distribution. We maintain no mailing list for the distribution of any such documents. When these copies go out, they go out to people who have requested them.

Senator DONNELL. Did the reprints bear on their face the language "Printed for the use of the Committee on Education and Labor"?

Mr. FALK. To the best of my knowledge, Senator, what you have in your hand is the same as ours; indeed it is one of the copies from our office supply of this document.

Reference was made by Mrs. Shearon yesterday—and I would like to remark on this in passing—to the fact that this document is included in a big, thick kit which is given out to people who ask for information on this subject from us. This item is somewhat beside the point to which I am addressing myself, but since distribution of this document has already received your attention, you will bear with me if I divert for a moment to indicate the reckless nature of some of the remarks made here yesterday. From that remark you would never guess the kind of letter which Mrs. Shearon had written to us, and in response to which that big, thick kit of documents was sent to her. I have here in my hands, Senator, the original letter which she wrote to the Social Security Administration, addressed to the Social Security Administration, Division of Publications, Social Security Building, Washington, D. C. May I read it, Senator?

Senator DONNELL. Yes.

Mr. Falk. This is on the letterhead of the United States Senate Committee on Labor and Public Welfare, and is signed by Marjorie Shearon, consultant, Committee on Labor and Public Welfare. In other words, it came to us from your committee, one of your officers, on your letterhead. The letter says——

Senator Donnell. What is the date?

Mr. Falk. This is dated June 18, 1947.

> I have been receiving the Social Security Bulletin from the time it originally appeared but last year my name was removed from the list, probably through inadvertence. Kindly send me the complete file from January 1946 to date, and restore my name to the mailing list.
>
> I should also appreciate having copies of any research memoranda on medical care, compulsory health insurance, voluntary health insurance, health insurance in other countries, workmen's compensation, and any other material along related lines in the field of health and medicine.
>
> Very truly yours,
>
> Marjorie Shearon,
> *Consultant, Committee on Labor and Public Welfare.*

The reply to Mrs. Shearon went forward on June 24, 1947, from Mr. W. L. Mitchell, Acting Commissioner for Social Security. He addressed the letter to

> Mrs. Marjorie Shearon,
> *Consultant, Committee on Labor and Public Welfare,*
> *United States Senate, Washington, D. C.*
>
> Dear Mrs. Shearon: In response to your request of June 18, we are sending you under separate cover a file of the Social Security Bulletin from January 1946 to date and adding your name as consultant to the committee, to the Bulletin mailing list. With these back issues you will also receive two most recent yearbooks, as well as published research memorandums and reports on health, medical care, and related subjects.
>
> The publications of the Social Security Administration are listed as they are released in the Bulletin and again in the Yearbook. Although a few items are now out of print, most of the material listed in either publication can be sent on request.
>
> Sincerely yours,
>
> W. L. Mitchell, *Acting Commissioner.*

I have here also, Senator, the list of documents that were sent to Mrs. Shearon. I don't know any particular point in reading the whole list to you. I would like to say merely for your information that it included 10 specific items from the Bureau of Research and Statistics, these being additional to the Bulletin and Yearbook, which are published by the Board, or the Administration, as a whole—did I say 10?

Senator Donnell. Yes.

Mr. Falk. Ten plus Senate committee print No. 5, Medical Care Insurance, the document to which we are referring.

I have taken 2 or 3 minutes to refer to this, to indicate in passing how easy it might be for Mrs. Shearon to give the committee what I regard as an erroneous impression as to the way in which, or the method by which, these documents are distributed.

I would like to repeat what I said earlier, that this document to which we are referring, and all other documents of ours—other than our regular periodicals, our bulletins and yearbooks—which are research and technical documents, documents produced in our Bureau, are sent out only on request. We maintain no regular mailing list whatever.

Now, if I may return to the document in question, a few words about what it is. I have indicated to you that it is the document in which we undertook to bring together in systematic, orderly and, I hope, understandable fashion, the basis for our estimates. I will direct your attention to the fact that in the letter of transmittal from Mr. Altmeyer to Senator Murray, from which Senator Donnell read a few excerpts yesterday, Mr. Altmeyer himself referred to this as follows—and I am reading now from the third paragraph of his letter:

> This study consists essentially of an estimate of the costs of medical care and an analysis of the problems involved in the application of social insurance principles in meeting these costs. This study undertakes to present various alternative solutions to the different phases of the problems confronted, rather than to foreclose further discussion by reaching definitive conclusions. But it was necessary at some points to select what seemed to be the best alternatives, since the analysis of other problems was dependent upon such selection.

I call attention to that because it emphasizes the point I have made, that this was primarily a cost document, a cost-analysis document. It also emphasizes a point which is material, namely, you can not make cost analyses unless you indicate what it is you are analyzing. You have to set forth clearly and explicitly the specifications of the scheme whose costs you are estimating. Consequently, in this document you will find on inspection there is set forth, I hope clearly and explicitly, the assumed specifications for a system of medical-care insurance. I trust you will find on inspection that those specifications as stated there are the basis for the cost estimates.

As Mr. Altmeyer's letter to Senator Murray indicated, since we were not addressing our remarks in this document to any particular bill or any particular system, there are specifications on many points which contain alternatives. Wherever we had alternatives that we thought reasonably useful, we retained them; consequently, the cost analyses are rather complicated, because at various points we submit alternative costs. If we will take the time later to look at the cost summary tables, you will see no alternative specifications. I will not go into that unless we have reason to do so.

I want to indicate briefly how these cost analyses were developed. If you will look at the table of contents you will note that, following the letters of request and transmittal references to the introduction there is a foreword and then there is a chapter 1 entitled "Introduction," which I will pass over for the moment.

Chapter 2 is titled "A preview of medical-care insurance in operation" which I will also pass over at the moment.

Beginning with chapter 3 we get down to the working details of this report. Chapter 3 deals with an analysis of the population eligible. You will find on inspection it is a rather detailed analysis of the characteristics, the size, and the composition of the people who may be covered by an insurance plan. Various alternatives are considered there.

Then come three chapters dealing with physicians and the medical services which they may furnish. Chapter 4 deals with services of physicians, chapter 5 with methods of paying physicians; and chapter 6 with estimated payments to physicians.

Senator Donnell. Mr. Falk, would you mind returning for a moment to page 2 of the document under the heading "Need for compulsory insurance"? I would like the record to show at this point the contents of that particular paragraph. You may either read it or I will read it into the record, whichever you desire.

Mr. FALK. On page 2, Senator?

Senator DONNELL. Yes. May I read just a paragraph:

> The need for medical care insurance through prepayment of the costs, summarized in the President's message of November 1945, is not reviewed here; as it has been documented elsewhere. The need is widely recognized. It is evidenced by numerous polls of public opinion, and it is generally agreed upon in professional as well as in nonprofessional circles. For a number of years the Social Security Board—specifically required by the Social Security Act section 702 to study and supply recommendations as to methods of providing economic security through social insurance—has considered possible methods of meeting this need, and particularly the alternatives of voluntary and compulsory insurance. As a result of its studies, it finally recommended compulsory Nation-wide medical care insurance as against a national system of public medicine—the only other alternative that has been proposed as capable of meeting the large-scale needs of the Nation.

I just wanted the record to show that that expression was made on page 2.

Mr. FALK. May I return to the outline? I am nearly through with this.

Following the three chapters dealing with physicians, and physicians' services, there are three chapters, Nos. 7, 8, and 9, dealing with hospitalization benefits; then a chapter, No. 10, dealing with dental care; No. 11 on home nursing care; No. 12 on laboratory services, medicines, and appliances; No. 13, payment to clinics and organized medical groups; No. 14, grants for research and education; No. 15, financing the program, and No. 16, administering a Nation-wide system of medical care insurance. Then follow some appendices.

The method followed in this document—and I am referring now to the material which begins with chapter 4—having developed the data concerning alternative estimates of population covered in chapter 3—

Senator DONNELL. Pardon me, Mr. Falk, I don't want to interfere with your presentation of this matter, but I can readily understand how, being so deeply imbued with all this subject, you might go into it in great detail, and very interestingly and very instructively; I understood, however, that what you intended to address yourself to at this point was what you state here is Mrs. Shearon's statement about the preference expressed in the report, that is, the preference she indicated according to your letter, and the statement in the record, that, quoting:

> That the capitation method and full-time salaried service are given preference over fee-for-service in the document prepared by us and printed for the Committee on Education and Labor.

I don't want to ask that your statements be unduly restricted, but I am wondering if you could give us as succinctly as possible at this time your statement on the specific point as to whether Dr. Shearon's statement as you give it here, and which I have quoted from your letter now, is or is not true, together with the reason for your conclusion.

Mr. FALK. The statement is not true, Senator, and on the line of presentation which I have been following, in one minute I will be on that point.

Senator DONNELL. I do not want to interfere, and if you think you should go further than my limited knowledge of it would induce me to think you should go, don't hesitate to do so, but I do hope we can confine your statement to reasonable limits.

This document that you are discussing here consists of 173 printed pages, with appendices embracing, I think, some 12 or 13 additional pages, with tables and so forth, and I can readily see that a gentleman who has given the care and thought to this matter that you have might readily see many things in here that could be discussed and would be of interest, but I think the point this morning is that you want to call our attention to what you deem to be an incorrect statement by Dr. Shearon, and that you are going to call our attention to why it is incorrect and where the incorrectness exists.

Mr. Falk. Yes, Senator, you are quite right, and I may say you are quite justified in having the impression that I am taking a long time to get to the point. But my story is substantially complete so far as giving the background of this. And, as I will indicate, I do not have to say very much more to get to the specific point. But, as you will see, it will be difficult for you to appreciate the nature of my challenge to Mrs. Shearon without some of this background. And I thank the committee members for their forbearance in permitting me to give you the introduction at such length.

Senator Donnell. I think we will show a reasonable latitude in according to you sufficient time, and I don't want to restrict you unduly, but I hope you will, so far as possible, give us, as briefly and succinctly as you can, your statement on this particular point, so we may not divert and digress into other fields at this time.

Mr. Falk. Yes, Senator, and I would like the record to show that I very much appreciate the kindness and generosity of the committee on this occasion and others, in giving me an opportunity to make my presentation as fully as is appropriate in the case.

The point I wanted to make was that in these successive chapters there was built up, step by step in each field, the cost estimates on the basis of the specifications given. Those cost estimates on the basis of the assumptions and specifications laid down in those chapters were then brought together in chapter 16, the chapter on financing the program. The over-all costs were given in terms of per capita cost for each type of service, and for all services combined, and then by multiplying those per capita costs by the various estimates of population coverages—aggregate costs were computed.

So that in chapter 15 you will find per capita costs and aggregate costs. Those in turn were then converted into pay-roll costs by relating the aggregate or per capita costs to the earnings of the persons covered by any particular specified coverage estimate. There were alternative coverage estimates, and so there were alternative pay-roll bases used to derive the cost in percentage. I emphasize that because there should be no misunderstanding that any use of per capita costs for the purpose of expressing the total cost or the cost of a particular class of benefits has any bearing whatever on the question of payment for services. The question of payment for services is developed in the working chapters to which I referred earlier.

Now, in chapter 5 the text is given over to presentation of the method of paying physicians, beginning on page 43. If you will turn to page 43 you will see by looking at the heading for a moment that after the introductory section there is a heading "Methods of Paying General Practitioners." Under that heading there are subheadings dealing with payment per service—fee-for-service; payment per insured person—capitation; payment by salary; combination of methods; and then the subheading "Administrative procedures."

In that section, which runs from pages 45 to 47, there is a brief discussion with respect to the administrative procedures involved with each particular or alternative method of paying physicians. Then on page 47 that section closes with the discussion of special incentive payments.

Senator DONNELL. Might I call to your attention at this point, Mr. Falk, on page 46 this language:

> A salary basis of remuneration involves establishment of an appropriate schedule of salaries for practitioners who have attained different levels of skill and experience. The fee-for-service basis requires establishment of a schedule of unit values for various kinds of service, agreements as to upward and downward adjustment of unit values in light of experience, keeping and furnishing detailed records of services rendered, and professional and administrative restraints against the padding of the volume of service reported by a physician. The capitation basis requires only a record of the number of persons who have chosen each physician as their practitioner and periodic agreement, on the capitation amount. It is therefore not surprising that in Great Britain, where the law guarantees to the general practitioners of each area the privilege of choosing the basis on which they are to be remunerated, local groups of insurance practitioners adopted the use of the capitation fee after they had had experience with various methods. South American countries have tended largely toward preference for salaries.

I just wanted to note that there was in that paragraph, as I see it, a contrast presented with respect to the amount of administrative record keeping as regards the two different methods, that is, the fee-for-service basis on the one hand and the capitation basis on the other hand.

I at least would hastily gather the impression that there was intended to be conveyed by that paragraph some indication of the relative simplicity of the capitation basis as compared with the fee-for-service basis.

One person may draw one conclusion and another person may draw another conclusion, but I just wanted to call your attention to that particular paragraph at this point.

Mr. FALK. I want to indicate, too, Senator, that that paragraph follows the three or four paragraphs in which are set forth specifically and, I believe, objectively the administrative steps that are involved with each particular method. The paragraph which you read is in effect a summary of the administrative procedures involved.

The paragraph which follows the one you read proceeds to indicate that:

> Combination methods have been used extensively, especially in Germany and other continental European countries; a basic stipend or guaranty (i. e., a partial salary) is supplemented by amounts which vary with either the number of insured persons (capitation) or the volume of service rendered fee schedules and fee for service).

In other words, various countries have used or have under consideration combinations of these various methods. Then further,

> At present, when there are extensive discussions of new proposals for general medical services in Great Britain, Canada, Australia, New Zealand, and South Africa, the use of salaries alone is being especially weighed against partial salaries supplemented by capitation fees.

Senator DONNELL. May I interrupt you at this point and call your attention to this: Going back to the paragraph which I read, there are two notes appended to that paragraph, note 1 and note 2. I do not know whether note 1 has any applicability to this particular point. If you think it does, I have no objection to its going into the record.

I observe that note 2 follows this sentence:

> It is therefore not surprising that in Great Britain, where the law guarantees to the general practitioners of each area the privilege of choosing the basis on which they are to be remunerated, local groups of insurance practitioners adopted the use of the capitation fee after they had had experience with various methods.

The note to which I refer, note 2, which follows that sentence, reads:

> Except in sparsely settled areas of Scotland—for example, the Highlands and Islands sections—where salary (part time or full time) and combination methods are used, and in the case of "own arrangers" (see Falk, I. S., Security Against Sickness, 1936, pp. 158, 167; and Armstrong, B. N., The Health Insurance Doctor, 1939).

Proceed, Mr. Falk. I just wanted to call to your attention that particular chapter, entitled "Methods of Paying Physicians," might vary, as the case may be, as regards the amount of records required between the fee-for-service on the one hand and the capitation basis on the other hand, as it says in this paragraph which I have read, and I quote:

> requires only a record of the number of persons who have chosen each physician as their practitioner and periodic agreement on the capitation amount.

The conclusion drawn is as follows:

> It is therefore not surprising that in Great Britain, where the law guarantees to the general practitioners of each area the privilege of choosing the basis on which they are to be remunerated, local groups of insurance practitioners adopted the use of the capitation fee after they had had experience with various methods.

Mr. FALK. Now, Senator, I would like to direct attention to the statement under which the presentation of these various methods was submitted in this Chapter V, Methods of Paying Physicians:

> It is proposed that alternative methods should be available for remunerating physicians. The practitioners who participate in the insurance arrangements, particularly the general practitioners, may be assured the right to choose, in each local (administrative) area, not only the method of practice (individual, group, etc.) but also the method of remuneration they prefer. These general comments on methods of payment should, however, be considered in light of desirable interrelations among the variety of essential practitioners and of subsequent proposals for remuneration of clinics, laboratories, and organized medical agencies.

Now I submit that any careful reading of this chapter will show that there is an objective and, I trust, informative submittal of the alternative methods of paying physicians available to you.

Senator DONNELL. Senator Murray, may I suggest that this particular chapter, entitled "Methods of Paying Physicians," might very appropriately be introduced in the record in full at this point, so that we might have in connection with Mr. Falk's discussion the benefit of having it in the record.

Senator MURRAY. You mean have it printed in the record?

Senator DONNELL. Yes.

Senator MURRAY. I have no objection. I thought the document itself was available or that reference to it will be sufficient, but I have no objection.

Senator DONNELL. I think perhaps, inasmuch as this particular chapter is not so long—from page 43 to page 48, inclusive, entitled "Methods of Paying Physicians"—it might be of convenience to the reader to have that particular chapter printed at this point, if there is no objection on your part.

Senator MURRAY. There is no objection.

Senator DONNELL. The reporter will kindly incorporate it in the record at this point.

(Chapter V, Methods of Paying Physicians, is as follows:)

V. METHODS OF PAYING PHYSICIANS

It is proposed that alternative methods should be available for remunerating physicians. The practitioners who participate in the insurance arrangements, particularly the general practitioners, may be assured the right to choose, in each local (administrative) area, not only the method of practice (individual, group, etc.) but also the method of remuneration they prefer. These general comments on methods of payment should, however, be considered in light of desirable interrelations among the variety of essential practitioners and of subsequent proposals for remuneration of clinics, laboratories, and organized medical agencies.

Two broad premises are assumed to apply to the physician who engages in practice either as an individual or as a member of a coordinated group and these have bearing on the method of payment: (1) The general practitioner or family physician is of primary importance in the first steps through which the patient seeks and obtains medical care, and in the assurance of balance, proportion, and continuity in medical service; and (2) coordination among general practitioners of medicine and other practitioners or agencies (such as medical specialists, dentists, nurses, hospitals, clinics) should be close and effective.

The following discussion of methods of payment deals primarily with the case of physicians who practice individually as general practitioners or as specialists (complete or partial). The problems and procedures involved in the methods of remunerating physicians who practice either general medicine or a specialty as members of an organized medical group or who perform some auxiliary laboratory services, are deferred to a later chapter; these special questions will be considered following a discussion of payment for hospitalization, as distinguished from payment for the services of physicians who care for hospitalized patients.

METHODS OF PAYING GENERAL PRACTITIONERS

In the proposed insurance system general practitioners may be remunerated in a number of ways, primarily according to their preference. A total sum of money available for the payment of doctors may be distributed among those who serve a particular population group, and the distribution may be proportioned among them in various ways.

Payment per service (fee-for-service)

This is the usual method of fee-for-service. The total sum available for general practitioner services furnished to the insured population group of an area is divided among the physicians serving the group, proportionately according to the amount of service rendered by each. In practice, this means distribution of the money according to the value of the services as determined by an agreed fee schedule in which each type of service is given a fixed value. If the nominal value of all services rendered does not exceed the total amount available for distribution, payment is made according to the fee schedule; if it exceeds the total, the value of each type of service is reduced proportionately. All general practitioners serving the local population group are paid at the same rates of payment per service. The individual physician's income thus depends on the amount of service and the kinds of services he furnishes to individuals in the insured population.

A variant of this method is payment per case attended. It has been used in various places but has generally been found unsatisfactory and is now little used, because of difficulties involved in reaching equitable definitions and decisions as to what constitutes a "case" of illness or medical attendance. Payment per maternity case (uncomplicated or with complications) and payment per surgical case of specified diagnosis are the common exceptions to these generalizations.

Payment per insured person (capitation)

Under this method, the total amount available to pay general practitioners is allocated among the physicians according to the number of persons eligible for benefit who have chosen each physician and whom the physician has accepted. The payment is intended to be remuneration for the obligation assumed by each physician to furnish such volume and variety of service—within the competence of the physician—as the eligible individual may need (during a specified period of time). Under this method, the physician is entitled to the average payment for each such eligible person without regard for the amount of service actually furnished. The physician receives the per capita payment for each person on his list, whether he has served the individual many times, once, or not at all during the period to which the payment applies. Since the physician is entitled to the per capita amount for an individual on his list even if no service has been furnished to that individual during a payment period, all physicians who have undertaken insurance practice in an area, taking them as a group, are entitled to payment for all persons in the area eligible to receive the insurance benefits. Accordingly, to assure fair total payments to the physicians of the area, administrative provision is made to distribute among all the participating physicians of the area per capita payments with respect to those eligible persons in the area who have not selected a physician.

As in the case of payment per service, all general practitioners in the area are paid at the same rate (a uniform per capita amount). The individual physician's total income thus depends on the number of insured persons who have chosen him and whom he has accepted, plus pro rata per capita amounts from the pool of funds for persons who have selected no physician. His income does not depend directly upon the amount of service he has rendered any individual patient or all of his patients. However, since in general the volume of service rendered is proportional to the number of patients or potential patients served, income will vary approximately with the amount of service rendered.

Payment by salary

By this method, physicians are paid at an annual rate, whole time or part time, for services to insured persons. The rates of payment are fixed by standards appropriate to salary payments, taking into account whether they are gross payments (i. e., the physician provides his own facilities) or net payments (the insurance system provides or arranges for the facilities and pays for them). The number of physicians available in an area on a salary arrangement must, of course, take account of the number of persons to be served. The grades and salaries of the physicians reflect agreements as to adequate levels of salaries, the attainments of individual physicians, whole-time or part-time arrangements, opportunities for advancement, etc. Thus, the individual salaried physician's income does not depend directly upon either the volume of service rendered or the number of actual or potential patients who choose him, but upon professional judgments of his capacities, upon the funds available to pay for medical services and upon the salary scales established.

Combination of methods

Various combinations of the three primary methods may be used. For example, a basic salary may be supplemented by amounts based on fee-for-service. Such a combination provides at least a minimum assured income for the year, and leaves room for variations in total income according to amount of service rendered. Similarly, a basic per capita payment supplemented by fee-for-service assures a minimum income proportional to the number of eligible persons who have chosen the physician, and allows for adjustments according to the volume of service the physician furnishes those who are on his list. Also, a basic salary may be combined with a capitation amount. Other combinations have been used, and many such can be devised to meet special circumstances.

Administrative procedures

The expected costs of general practitioner services for the insured population are usually computed on a capitation basis (as will be done in ch. VI). The same amounts may be used as the financial basis for each method of remuneration which local groups of physicians may choose from among the alternatives open to them.

The conversion of capitation amounts into salaries may be illustrated (with the help of the figures developed in the next chapter). If there are 1,500 persons eligible for benefit (insured workers and qualified dependents) per general practitioner, an annual capitation amount of, say, $7.50 can be replaced by a schedule of annual salaries whose average is $11,250 per general practitioner. In both cases, the figures represent gross payments. If the facilities of practice are furnished by the insurance system and at its expense to the physician practicing on a salary basis, the average gross salary needs to be reduced by an amount equal to that spent by the insurance fund so that the average salary paid may represent an average net income equivalent to the average gross income of $11,250.

Conversion of the capitation amount to a fee-for-service basis involves the following steps: (*a*) A fee schedule is established in which each type of service has an appropriate value in units of service (and equivalent dollar amounts); (*b*) each physician keeps and periodically furnishes a record of the services he rendered, so that these service records, in conjunction with the adopted fee schedule, constitute his claims or bills on the insurance fund; (*c*) when the aggregate bills submitted by the physicians of an area do not exceed the total amount available for their remuneration (i. e., the capitation amount multiplied by the number of eligible persons in the area), the physicians are paid according to their bills; (*d*) when the aggregate bills exceed the money available, the rate of remuneration per unit of service is adjusted downward by dividing the total sum available by the total units of service rendered, and the payments to physicians are made according to this rate; (*e*) when the aggregate bills continue to fall short of the money available, beyond some agreed margin, periodically (say, once in 3 or 6 months or at the end of the year) the rate of remuneration per unit of service may be adjusted upward and, from the sums previously allocated for payments to general practitioners, supplementary payments may be made to bring the aggregate payments up to the agreed level. In actual practice, the reports from physicians would probably be made monthly and the dollar values of the units determined monthly or quarterly, as is the practice in areas where this method of payment is used in prepayment plans.

A salary basis of remuneration involves establishment of an appropriate schedule of salaries for practitioners who have attained different levels of skill and experience. The fee-for-service basis requires establishment of a schedule of unit values for various kinds of service, agreements as to upward and downward adjustment of unit values in light of experience, keeping and furnishing detailed records of services rendered, and professional and administrative restraints against the "padding" of the volume of service reported by a physician.[1] The capitation basis requires only a record of the number of persons who have chosen each physician as their practitioner and periodic agreement on the capitation amount. It is therefore not surprising that in Great Britain, where the law guarantees to the general practitioners of each area the privilege of choosing the basis on which they are to be remunerated, local groups of insurance practitioners adopted the use of the capitation fee after they had had experience with various methods.[2] South American countries have tended largely toward preference for salaries.

Combination methods have been used extensively, especially in Germany and other continental European countries; a basic stipend or guaranty (i. e., a partial salary) is supplemented by amounts which vary with either the number of insured persons (capitation) or the volume of service rendered (fee schedule and fee for service). At present, when there are extensive discussions of new proposals for general medical services in Great Britain, Canada, Australia, New Zealand, and South Africa, the use of salaries alone is being especially weighed against partial salaries supplemented by capitation fees.

Special incentive payments

Special methods of payment may be justified to encourage arrangements and services likely to prevent illness and disability. Incentives toward prevention may be introduced into the methods of payment. For example, the per capita sum available for the remuneration of general practitioners might be divided into parts, such as (*a*) a basic capitation fee, and (*b*) special fees for special services, such as initial and subsequent periodic physical examinations, immunizations, and other approved preventive procedures. Such an arrangement would involve additional record keeping and "paper work" where the capitation method of payment is used, but it may be regarded as desirable by both professional and administrative representatives.

---

[1] For some details of "prorating" and for objective methods of controlling excessive volumes of service under a fee schedule, see Sinai, N., Hall, M. F., and Holmes, R. E., Medical Relief Administration (Final Report of the Experience of Essex County, Ontario), 1939. Concerning the California Physicians' Service, see the testimony of T. H. Kelly in Wartime Health and Education: Hearings before a subcommittee of the Senate Committee on Education and Labor on Senate Resolution 74, 78th Cong., 2d sess., pt. 6, September 18–20, 1944, p. 2084. For Farm Security Administration plans, see the Administration's Annual Report, 1940–41, of the Office of the Chief Medical Officer, p. 26; and Activities of an Experimental Rural Health Program in Six Counties During Its First Fiscal Year, 1942–43, March 1945, p. 9. See also, for Great Britain: Report of the Royal Commission on National Health Insurance, 1928, pp. 181–186; and McCleary, G. F., National Health Insurance, 1932, pp. 113–115.

[2] Except in sparsely settled areas of Scotland—for example, the Highlands and Islands sections—where salary (part time or full time) and combination methods are used, and in the case of "own arrangers" (see Falk, I. S., Security Against Sickness, 1936, pp. 158, 167; and Armstrong, B. N., The Health Insurance Doctor, 1939).

Whether or not provision is made for such special incentive payments for preventive services, other types of subdivisions in the total amount available for remuneration to general practitioners are desirable. Some of these special funds may properly come from the amounts available for practitioners generally; some should come from a supplementary fund. (See ch. VI). For example, a small fraction of the total money available may be held in a special fund to provide periodic stipends to physicians for expenses incidental to attendance at postgraduate or refresher courses, or allowance might be made in the rates of payment to provide income for this purpose; special mileage or equipment allowances should be reserved for practitioners whose patients are scattered over a large area or who practice in an isolated place, unless this factor is adequately reflected in rates of payment; special amounts may be reserved for the purchase and supply of unusually expensive medicines used or dispensed by physicians, especially in rural areas for patients to whom a pharmacy is not readily available; and expenditures for other desirable special purposes may be indicated according to the methods of payment used.

METHODS OF PAYING SPECIALISTS

The procedures used in paying for specialist services should obviously be permitted to vary according to the nature of the specialist service, the preference of the specialists, and the circumstances prevailing in different communities. Diverse methods are already extensively used in the United States; payments are made through fee schedules (by service or by case), whole-time or part-time salaries, fees for sessions of specified length (these are really part-time salaries), or capitation fees for specialties in which this method is applicable (e. g., pediatrics). Combinations of methods would be appropriate not only for certified specialists whose practice is entirely limited to a specialty but also for physicians who have been certified for special skill and competence in a particular class of services and who also engage in general practice. In any case the procedure should be determined by agreement between representatives of the physicians concerned and the officers of the insurance administration. As in the case of general practitioner services, the aggregate payments to specialists must remain within the total amount of money available for specialist services, whatever the methods of payment.

In a particular community, the procedure adopted to pay for specialist services may be different from that adopted to pay for general practitioner services. In general, it may be expected that the plan for paying the specialist would be on the basis of fees for services rendered or on a salary basis (whole time or part time), or a combination of these two; pediatric services furnished by qualified specialists may present the most common exception, using annual capitation fees more extensively than other specialties. In determining the method of payment adopted for specialists, the administrative authority should have responsibility for assuring that the methods selected are such as will result in a satisfactory quality of service.

As with general or family practitioners, the rates of expenditure to be suggested in the following chapter for specialist services will be intended to be averages to apply nationally to the entire insured population. Variations in the average rates may be necessary among different parts of the country and among different types of communities, leading to some local average rates higher and some lower than the national averages. Payments to specialists, as with respect to general practitioners, would have to be limited through the customary devices surrounding the use of a fee schedule or other method of payment, so that total disbursements for the insured population of an area are within the total amounts for these services available from the insurance funds.

Senator DONNELL. All right, Mr. Falk, you may proceed.

Mr. FALK. With respect to dentists, I would like to call attention to the remarks made in the chapter on dental care.

Senator DONNELL. What page is that?

Mr. FALK. I believe it begins on page 103, with the paragraph on "Status of Dentists".

Following a few sentences which are not pertinent to the point we are considering, line 8 of that paragraph states:

> Individual dentists and dental groups should have the same choice of methods of remuneration provided physicians (ch. V).

Then in the next section, over on page 104, the third paragraph on that page, it says:

> Under an insurance program, the incomes of dentists—like those of physicians—would depend upon the rates of payment, whether the dentist is a general practitioner or a qualified specialist, and the size of the practice he can achieve for himself. With payments on a fee-for-service basis, the individual dentist's income will depend on the number and kinds of services he renders; on a capitation basis, it will depend on the number of people who choose him; on a salary basis, it will depend on his skill and attainments.

Senator DONNELL. I take it in that case likewise, the capitation basis would be much simpler from the standpoint of the keeping of records, would it not, Mr. Falk, than either of the other bases?

Mr. FALK. It will be much simpler than fee-for-service for the dentist, but not any simpler than the salary basis.

Senator DONNELL. You may be quite right on it. I was contrasting between the two, and the same point applies there as applies on page 46 in the paragraph that I read. Is not that correct?

Mr. FALK. Quite so.

I want to emphasize that in each of these chapters—and I won't belabor the point by defining all the specifications—I believe we followed carefully, meticulously, the principle that the methods of payment should be left to the choice of the practitioners, within the limitation, of course, that the practitioners had to choose methods that were compatible with the finances and the orderly administration of the system but within reasonable boundaries that might be set down. The choice of methods should be left to the practitioners.

Senator DONNELL. Mr. Falk, don't you think, if I might interpose for a moment, that a paragraph such as the one I read a little while ago from page 46, which contrasts on one hand the rather complicated, I would think, at least detailed—if complicated isn't the word—list of records that would have to be kept in the case of the fee-for-service basis as compared with the simplicity as regards the capitation basis, and then, following that contrast, a statement that

> It is therefore not surprising that in Great Britain, the local groups of insurance practitioners adopted the use of the capitation fee after they had had experience with various methods,

that that might well be a pretty strong point in the mind of the reader of this document in favor of our country likewise following the capitation plan?

Here is Great Britain, an English speaking country, whose customs are very similar to our own in many respects. Local groups of practitioners, after having tried the more detailed and possibly more complicated systems, then come to the conclusion that the capitation fee basis is the better plan, and the writer of this mentioning that it is therefore not surprising that they should have come to that conclusion, and being documented by this note down here, "Except in sparsely settled areas of Scotland—the Highlands and the Islands sections"—the point I am making is, wouldn't the conclusion be pretty clear, just as Dr. Shearon has drawn it here, that while you don't say in so many words in here, in this Senate committee print no. 5, that you favor the capitation plan, wouldn't the conclusion be quite legitimately drawn by the reader from that paragraph that I read into the record, just as Dr. Shearon has drawn the conclusion, that you gentlemen were expressing a preference for the capitation plan?

Mr. FALK. I would not think so. I would disagree entirely with you, Senator, much as I regret to do that.

I would say that a reader would know from this that we were informing him that Britain has had some experience with this; that in Britain, where the law guarantees to the general practitioners of each area the privilege of choosing the basis on which they are to be remunerated, the local groups of practitioners chose the capitation fee.

Senator DONNELL. And it is not surprising that they did so.

Mr. FALK. Right, because any fair statement of these methods must point out, as we pointed out here, that one method involves more complications than another. It informs the reader as to what the experience in Great Britain has been, what the doctors themselves did on the basis of their own choices under the freedom of choice which the law gives them, and then it goes on to tell about combinations of methods which are under discussion or that have been adopted in various countries.

Senator DONNELL. And the system that does involve that more complicated method is, as you point out in this paragraph, the fee-for-service basis as compared with the simplicity of the capitation basis which, this sentence says:

> requires only a record of the number of persons who have chosen each physician as their practitioner and periodic agreement on the capitation amount.

That is correct, isn't it?

Mr. FALK. You are reading it correctly. I will stand on my position that I do not believe there is anything in that statement other than a factual statement of the experience in Britain; and this remark that, in light of the complexity which has been set forth, and which I believe is an accurate account of how these methods work, it is therefore not surprising that the British physicians on their own motion and through the selection guaranteed them by law chose to do what they did.

Senator DONNELL. Now, Mr. Falk, your letter to Senator Murray, which is in the record this morning, says, "Mrs. Shearon's statement about the preference expressed in our report is untrue."

Now I am not undertaking to decide, as between you and me, whether your opinion is right or whether mine is right, and I don't know whether this is the only paragraph on which Dr. Shearon relied. I turned to her a moment ago, after I read that paragraph into the record, and asked her if she didn't think it was important. She said she did, and intended to comment upon that in her future rebuttal, in her future testimony.

The point I am making here is that it would appear at least tentatively to me that from this one paragraph—and it is referring to Great Britain, an English speaking country, just as we are an English speaking country, with customs somewhat similar to our own—that after a comparison of the two different plans, one, the rather complicated or detailed plan, the other a very simple plan, that, as the writer therein said, "It is therefore not surprising that * * * the local groups * * * had adopted the use of the capitation fee," and then supplemented it by this note: "Except in sparsely settled areas of Scotland—the Highlands, and the Islands sections—" I think, tentatively at any rate, a person could very properly draw the very conclusion that Dr. Shearon did from that paragraph alone.

Now maybe that isn't the one she is relying on; I don't know. I never discussed this question with her, as far as I can recall.

Mr. Falk. May I comment on that after I first call attention to one other section of this volume?

Senator Donnell. Very well.

Mr. Falk. I want to turn back to chapter II. There we have a chapter which undertook to give the reader an over-all general view of how it was conceived this particular system of health insurance set forth in this volume might actually operate.

Senator Donnell. To what are you referring now?

Mr. Falk. I am referring to chapter II, which begins on page 11. It is entitled "A Preview of Medical Care Insurance in Operation."

I want to point out that in chapter II, beginning on page 11, following the introductory paragraphs, there is a section under the heading "Health Insurance As Seen By The Insured Person And His Family."

In this section which begins on page 11, there is set forth what the specifications assumed for this volume would require of the insured family one way or another. On pages 13 and following, beginning with the third new paragraph on page 13, there is set forth what the relations of the insured persons and members of their families would be with the doctors of the community. There are set forth sequentially in accordance with the choices which the doctors or the particular family's doctor have made as to the methods of payment. There is a paragraph dealing with the case of the family if the doctors in the communities have chosen to receive their payments from the insurance system on a fee-for-service basis or on a salary basis. The next paragraph—this is the one at the bottom of page 13—deals with the case where the doctors have chosen to be paid on a capitation basis. On page 14, it deals with the case where the doctors have chosen to practice as an organized group.

On page 15, there is a section entitled "Health Insurance As Seen By The Doctor." Beginning at the bottom of page 15, there is a paragraph which proceeds, as in the case of the family, to consider the case of the doctor who has chosen to receive payment on a fee-for-service basis. On page 16 there is a paragraph that deals with the case of a doctor who is receiving payment on a capitation basis. Then there is a paragraph on doctors who prefer to be paid on a salary basis for their insurance practice.

Senator Donnell. Pardon me, Mr. Falk. I notice on page 16 this language—this is the beginning of the first full paragraph:

> A doctor who is receiving payment on a capitation basis will need only to keep a file of the names of those insured persons who are currently on his list as having chosen him as their physician and whom he has accepted. Periodically, presumably once a month, he will receive from the insurance system the agreed-upon per capita payment for each person on his list. In addition, if the capitation amount has been calculated on the basis of all the insured and not merely those who have chosen their doctors, he will receive a prorata share of payments for those insured persons who are not on any doctors' lists. Since it will be his responsibility to furnish all needed services—that may be expected from a general practitioner or family physician—to those persons, and since he will be paid the same amount per person, regardless of how many services he has

> furnished any particular person on his list, there will be no need for him to provide the insurance system with a detailed accounting or bill for particular services rendered. The individual physician will decide for himself the maximum number of insured persons whom he is willing to accept on his list,

then there is a note interpolating

> except that the insurance system might not permit him to be paid for any length of time for more than a specified maximum number, (assuming that number choose him) and therefore how much time, if any, he will reserve for noninsurance practice.

There again, Mr. Falk, there is emphasis, I take it, on the simplicity from the standpoint of the doctors, at any rate, in the keeping of records on the capitation basis as contrasted with the fee-for-service basis. Is not that emphasized in that paragraph?

Mr. Falk. I do not think so, Senator, because what it is is a contrast from the preceding paragraph. You will note that the preceding paragraph says—that is at the bottom of page 15:

> A doctor who has chosen to receive payment on a fee-for-service basis, will need to keep records of services provided to insured persons. Periodically, probably once a month, the doctor will submit to the local insurance agency an accounting—in effect, a consolidated bill—for insurance services rendered during that period, possibly including identification of the insured persons served. Payments to the doctor will be according to the bills submitted, except that if the aggregate of such bills from all doctors in the community exceeds the funds available for all payments to doctors on a fee-for-service basis, the bills will have to be prorated down. If the aggregate bills are substantially less than the total funds available for these payments, the surplus would need to be held—for a while—as a contingency reserve against subsequent periods when the aggregate bills may be in excess of the funds; if a surplus persists, either too much money was allocated for the services or the fee schedule needs to be reinspected for upward revision.

Then you will note, having said that, the text goes on to say:

> A doctor who is receiving payment on a capitation basis will need only to keep a file of the names, etc.

Senator Donnell. The word "only" is to my mind a very significant word.

Mr. Falk. Certainly, Senator, but it is meaningful, having read the preceding paragraph.

Senator Murray. Let me ask this question. If this paragraph at the bottom of page 15, which discusses the fee-for-service system stood by itself in your book, wouldn't it be assumed by the chairman here that that was favoring the fee-for-service proposal? Wouldn't it look as though you were attempting to make an argument in favor of the fee-for-service system?

Mr. Falk. I believe you are right, Senator.

Senator Murray. If it is taken alone?

Senator Donnell. Yes, but, Senator Murray, I call attention to the fact it isn't here alone. It is in conjunction with the next sentence, which immediately says, "A doctor who is receiving payment on a capitation basis will need only to keep a file," etc.

Senator Murray. Well, isn't that true? Is that a false statement?

Senator Donnell. Certainly it is true.

Senator Murray. Then you are merely stating what the fact is.

Senator Donnell. I am not saying Mr. Falk is not stating what the fact is. My point is that obviously in this language, as I see it, there is a very clear suggestion that there is a simplicity about the capitation plan that does not apply to the fee-for-service plan, and I have some little question in my own mind as to whether the sentence in the preceding paragraph, which reads, "Payments to the doctor will be according to the bills submitted," and so forth, should not have been slightly supplemented by saying that those bills would have to be itemized in considerable detail in order that the Government might know whether it was paying only the reasonable value of the services that were rendered.

To my mind, while I am not criticizing this language—and it may well be that the payments will be made according to the bills submitted—I would say that it would appear to me that any careful consideration of a compulsory insurance plan, when the doctors are paid on bills submitted, would require that—just as I get my bill from the grocer, or should get it, each day showing whether it was sugar or tea or coffee that I bought—it will not be merely an aggregate, but the doctor is going to have to go into great detail and show what he prescribed and what he did and how often he went and the nature of the illness and something of the treatment. There is going to be a lot more complexity to it.

So the point I am making is not a criticism of Mr. Falk on the ground that his statement is untrue here in saying that a doctor who is receiving payment on a capitation basis will need only to keep a file, and so forth. My point is that the language is clearly pointing out the simplicity of that plan from the doctor's standpoint as against the fee-for-service plan, and I think that has a direct bearing on whether or not Dr. Shearon's conclusion is or is not true. Mr. Falk has not said it is a mistake. He has used—I don't know just what he means by the word "untrue," whether he means intentionally false or whether he means that it is inaccurate or inexact. At any rate, his letter says, "Mrs. Shearon's statement about the preference expressed in our report is untrue."

I am inclined to feel up to the present point that the evidence would amply justify her in the conclusion that she has drawn. Now maybe her conclusion is wrong. Maybe you or I wouldn't draw it, or maybe we would draw it as she did, but I haven't yet observed from Mr. Falk's testimony anything that, to my mind, corroborates his statement in this letter introduced in the record today that Mrs. Shearon's statement is untrue.

Mr. Falk. Senator, may I return now to what she said and let the record show for those who will read it whether or not my statement is correct?

Senator Donnell. Yes, sir.

Mr. Falk. She said—I am reading from her prepared testimony, page 19—

> That Federal officials have the fullest intention of changing completely the present form of medical practice is indicated in a report submitted to this committee in 1946 entitled "Medical Care Insurance a Social Insurance Program for Personal Health Services," prepared by Mr. I. S. Falk.

Now, up to that point, and I emphasize her words by repeating,

> That Federal officials have the fullest intention of changing completely the present form of medical practice is indicated

by this report, I submit that such is not true and cannot be sustained by this report. On page 21——

Senator DONNELL. I wonder if I might not interrupt you as to page 19, before we get away from it. You have not attacked that statement at all in your letter of yesterday. The thing you are attacking in your letter of February 4 is not her statement—

> That Federal officials have the fullest intention of changing completely the present form of medical practice.

I read what you say:

> Mrs. Shearon founded a major portion of her testimony on the alleged undesirable consequences of remunerating physicians by capitation payments (Testimony, p. 16 and following), and then stated (Testimony, p. 19) that the capitation method and full-time salaried service are given preference over fee-for-service in the document prepared by us and printed by the Committee on Education and Labor (Medical Care Insurance, Committee Print No. 5, July 8, 1946).

Then you proceed:

> The alleged bad consequences of capitation payments are, to say the least, grossly exaggerated.
>
> Mrs. Shearon's statement about the preference expressed in our report is untrue, and I should be glad to have an opportunity to give the subcommittee accurate information about that report and what we said in it bearing on methods of paying physicians.

Now as I read what you have said, Mr. Falk, up to this point in your letter, certainly you never attacked her statement that Federal officials have the fullest intention of changing completely the present form of medical practice.

Just a moment ago, when you cited that and charged that with being an untrue statement, you were getting onto an entirely different subject than the one which we are proceeding on here in this letter that you addressed to Senator Murray.

Mr. FALK. I apologize for having stopped reading at that point. May I continue to read it?

Senator DONNELL. Certainly.

Mr. FALK. (Reading)

> Prepared by Mr. I. S. Falk, who was largely responsible for S. 1606 of the Seventy-ninth Congress and S. 1320 which we are now considering. (6) In regard to the methods of paying physicians he repeatedly indicates that the Government would use the capitation method or a full-time salaried service rather than the fee-for-service.

Senator DONNELL. And that is the sentence right there, Mr. Falk?

Mr. FALK. And the next one.

Senator DONNELL. If I may interrupt, that one and possibly the next one are the ones that you are attacking here in your letter, and not the ones that you read a little while ago, when you stopped and said that you challenge the truthfulness of that statement.

Mr. FALK. Senator, it is my understanding of her testimony that among the evidence for the alleged plans on the part of Federal officials of changing completely the present form of medical practice—her testimony rests very heavily on the intent to change the method of payment, to force doctors into public clinics, and so forth.

Now I have directed attention to her emphasis on the method of payment which is implied in that first page and spelled out further in her testimony, and then goes on for two sentences more, which are her statements on page 21.

Senator Donnell. Now I don't want to cut you off, but you speak of two sentences. The second sentence of those two reads—in her testimony on page 19:

> In computing administrative costs and in giving illustrations of the way things would work, he refers to the capitation method as though it were the desirable one and the one the medical profession would choose.

I respectfully submit, Mr. Falk, that both the paragraph on page 46 which I read, showing, according to the writer of that report, that—

> It is therefore not surprising that in Great Britain, where the law guarantees to the general practitioners of each area the privilege of choosing the basis on which they are to be remunerated, local groups of insurance practitioners adopted the use of the capitation fee—

and the paragraph on page 16 which, as I see it, undertakes to emphasize the point of great simplicity on the part of the capitation system from the standpoint of the doctor, amply justify the understanding of Dr. Shearon in the second of those two sentences, that—

> in computing administrative costs and in giving illustrations of the way things would work, he refers to the capitation method—

that is, you refer to the capitation method—

> as though it were the desirable one and the one the medical profession would choose.

Mr. Falk. Senator, I submit that nowhere in this document can Mrs. Shearon or anyone else indicate any place where I refer to the capitation method as though it were the desirable one in my opinion, nor can anyone show any place in this document where I said it is the one that the medical profession would choose. And, I say I challenge Mrs. Shearon and anyone else to cite the places in this document where I repeatedly indicate that the Government would use the capitation method or full-time salary service rather than the fee-for-service.

I agree with you that I did say that the British doctors, on the basis of their own experience and in utilizing the selection guaranteed them by law, did shift from fee-for-service payments to capitation payments in most places in Britain and——

Senator Donnell (continuing reading):

> Except in sparsely settled areas of Scotland—for example, the Highlands and Islands sections.

Mr. Falk. I said in most places.

Senator Donnell. Not the Highlands and Islands sections. That is your thought, isn't it?

Mr. Falk. Yes, sir.

Senator Donnell. All right.

Mr. Falk. Now, what I say, that is, I have recorded what the British experience was and what the current discussions were in other countries of the world. I think that was a fair and objective statement of the fact. What I am saying is that it is reckless misrepresentation to come before this committee and to say, as Mrs. Shearon has said, that the Federal officials have these various intentions, and that, in this document I said these things as my opinions and that I repeatedly indicated one thing as against another, and that I referred to the one as the more desirable and the one the medical profession would choose.

Senator DONNELL. Do you think it is false and reckless for her to say that you refer to the capitation method—

as though it were the desirable one and the one the medical profession would choose?

Mr. FALK. I do, sir.

Senator DONNELL. And you make that statement as to the recklessness and falsity of it, notwithstanding the existence of this paragraph on page 46 that I read, pointing out the fact that it is not surprising that in Great Britain, except in the Highlands and the Islands sections, the physicians have gone over to the capitation plan, and notwithstanding the fact that on page 16, there is relative simplicity of the capitation plan from the fee-for-service plan? You make that statement; is that correct?

Mr. FALK. I think with that amendment, I will agree with you, that the record will show that in their context, those are cool, objective, and impersonal statements, and that they do not indicate any preferences on our part or on my part. They give the reader the privilege of judging for himself, and they leave it to the physician. It is emphasized again and again in the document that it is our belief that the choice as to the method is one which should be available to the physicians and the dentists and that the statute should guarantee them that choice.

Senator MURRAY. And this bill that we have points that out. It makes express provision in there that they should have this choice. All through your statement you emphasize that the practitioners are the ones to determine which method they should follow.

Mr. FALK. I think that it is as clear as it may possibly be or needs to be in the bill which is before you, S. 1320, that the statute, if enacted, would guarantee to the physician the right to choose the method of payment from among various methods which are explicitly set forth or various combinations of them or modifications of them which may be agreed upon.

Senator DONNELL. Mr. Falk, I will not insist on my interpretation of either the paragraph on page 46 or the paragraph on page 16. I will just let them stand by themselves, without any interpretation on my part, but I want the record perfectly clear that, notwithstanding the fact of the paragraph on page 46, telling about the experience in Great Britain, the note referring to the Highlands and the Islands section, and notwithstanding the paragraph on page 16, whatever the proper construction may be, you assert here this morning that Dr. Shearon has been reckless and false in stating that you refer to the capitation method as though it were the desirable one and the one the medical profession would choose. I want the record to show that just as clearly as it is possible for the English language to show it.

Mr. FALK. I will stand on the words I used, Senator, and I would repeat that any fair-minded person reading that document, seeing what is said there at each place and in its context, I believe, will agree with me that the statements which I read from pages 19 and 21 of her prepared testimony are a gross misrepresentation of that document and what we said in it. I will stand on that on the record.

Senator MURRAY. Now, Mr. Chairman, it is not surprising to me that Dr. Shearon would make these exaggerated statements. I am not criticizing her for that. She is a special pleader here. She has been carrying on propaganda here for a number of years and she tries in every way to draw inferences which are entirely foreign to the objects that we have in mind. All through your testimony that you have given here before this committee you have tried to make it clear that you have no special interest in this matter except from the standpoint of your trying to aid the committee in determining what they should do about this problem.

Now, Mrs. Shearon is, I think you have to admit, here for a special purpose. She is registered as a lobbyist and she is working to make it appear that we are engaged in some kind of a conspiracy, which is absolutely untrue, and I think that we are wasting a lot of time nibbling at technicalities here and indulging in all these prolixities. It seems to me that it is all argument that is going on here this morning and not testimony that is going to be helpful to us.

Senator DONNELL. I think, Senator Murray, that it was your suggestion—that I thoroughly concurred in—that Mr. Falk be given an opportunity to give his statement, whether it be testimony or not, and insofar as the observations made by you may refer to my interrogation of him, you may be right. I am not undertaking to say that I am free from fault in interrogation, but it would appear to me that the points that have been developed here with respect to the paragraph on page 46 and the paragraph on page 16 are very closely in point in determining whether or not Mr. Falk's observation in his letter that "Mrs. Shearon's statement about the preference expressed in our report is untrue," and is very closely in point on whether or not Dr. Shearon is false, reckless—I have forgotten the other adjective or adjectives, if there were some others—when she says that Mr. Falk "refers to the capitation method as though it were the desirable one and the one the medical profession would choose."

There may be room for argument as to whether a conclusion was correct or not. It may be that maybe Mr. Falk is right in his idea. There may be plenty of people who will concur with him. On the other hand, I think there may be room for argument as to the point that I have emphasized, that this record thus far—and I may say that as far as I know, I have never seen this document until yesterday. It is only just by mere chance, plus the statement of Mr. Falk, that I have observed these particular paragraphs. There may be lots of other things in these 175 pages or thereabouts that may have a bearing on this. It would appear to me, inasmuch as Mr. Falk has made the charge of untruthfulness, recklessness, falsity, and so forth, here this morning, that these things are very closely in point, and I think it is well that the record show just what it has shown this morning.

Mr. FALK. Senator, I wonder if it would be fair if I may ask that the record show any additional citations besides those you have referred to which Mrs. Shearon would wish to indicate as supporting her statement about repeated indications, if I recall?

Senator DONNELL. I may say, Mr. Falk, in that connection, it was understood between Senator Murray and myself this morning that Dr. Shearon will be given the opportunity to rebut your statement. In due time, she will be placed back upon the stand and will be interrogated quite thoroughly along those lines.

Mr. FALK. Shall I proceed?

Senator DONNELL. Yes, sir.

Mr. FALK. The second point to which I referred——

Senator **Donnell**. That is in your letter of February 4, to Senator Murray?

Mr. **Falk**. Yes, sir.

Senator **Donnell**. Very well.

Mr. **Falk**. I said:

> Mrs. Shearon's testimony about the relation between the capitation method of payment and free choice of doctor completely confused two separate matters: change of doctor, and referral from a general practitioner to a specialist. It is my impression that the discussion of her testimony on this subject left the subcommittee members misinformed as to our views (and possibly also as to the pertinent provisions in S. 1320). I should be glad to clarify this subject for the subcommittee.

Now I have not attempted to prepare a summary of the testimony or cite back to it. I thought that I could very briefly indicate one or two points which I thought would be helpful to you. It was my——

Senator **Donnell**. May I ask you to tell us, please, what testimony—I quote from your letter:

> about the relation between the capitation method of payment and free choice of doctor—

it is to which you refer in this paragraph 2 of your letter to Senator Murray of February 4?

Mr. **Falk**. I haven't had the transcript long enough this morning, Senator, to identify the pages at which it occurs. I only received it a few minutes before I came over here.

Senator **Donnell**. You had her prepared statement, however, several days ago, Mr. Falk, and you have made this statement in your letter of February 4, obviously bearing in mind what her testimony is, and even if you haven't had the transcript, I assume that when you prepared this letter of February 4, you knew what that testimony was. Even if you can't give us the book and page, maybe you can tell us what the testimony was that you now think confused two separate matters.

Mr. **Falk**. What I had in mind was a good deal of discussion and testimony that departed from her prepared statement. There were extensive discussions yesterday morning on matters that were quite afield from the specific text bearing on this point that if there is a capitation method of payment, a patient has to choose his doctor in advance. Then there was a good deal of discussion about having to give up that doctor and change that doctor in the event it turned out, to use your own illustration, that the patient was found to have a case of diabetes and had to go to someone who was an expert.

I wouldn't profess to know how much of that discussion was specifically documented in the advance prepared testimony and how much of it arose out of the colloquy here. Now it was in connection with that, and it was to that that I had reference in my statement that her testimony about the relation between the capitation method of payment and free choice of doctor completely confused two separate matters: Change of doctor and referral from a general practitioner to a specialist.

Now I don't want to try to repeat or summarize extemporarily some 15 or 30 or 45 minutes of discussion here, but I believe that the colloquy developed the idea and may have left the impression that where the physicians have chosen to be paid on the capitation method the patient has to choose the doctor in advance and then has to go through a great deal of difficulty, possibly a great deal of Government red tape and possible delays, in order to change the doctor so that the patient may be able to go to a specialist, etc.

Senator DONNELL. Pardon me, Mr. Falk. In that connection, on page 13 of this Senate committee print No. 5, down at the bottom of the page, I note this statement, which I assume was issued with your concurrence, which reads:

> If the doctors in the community have chosen to be paid on the capitation basis—that is, according to a fixed amount of money per year or per month for each insured person who has chosen the doctor—insurance persons will be encouraged to select a doctor in advance of actual illness, in order that the doctor and the insurance system may know how many persons are relying on a particular physician for care in case of illness or need for preventive service or advice. A person who failed to make an advance selection could, of course, still request the doctor's services when the need arises. An insured person could change doctors if he wished, but where the insurance system pays the doctor by the capitation method, he would be required to notify the local administrative agency or the doctor to transfer his name from one doctor's list to another—in order that only one doctor may receive the capitation payment for him. Unless he make such a change, he will not need to show his insurance card to his family doctor more than once in each benefit year.

The point to which I direct your attention is that as I read this language in that paragraph, you gentlemen are pointing out that if doctors are going to be paid on a capitation basis, there is an encouragement to insured people to select the doctor in advance of the actual illness, and then if a person gets a doctor whom he doesn't want, when his diabetes turns up unexpectedly, that he has to go around and notify the local administrative agency or the doctor to transfer his name from one doctor's list to another.

Mr. FALK. That is precisely the error—your last statement.

Senator DONNELL. What is in error?

Mr. FALK. Because what is confused there is if the patient is found to have diabetes, to take your example, sir, and the physician advises or indicates or determines that the patient needs the care of a specialist on diabetes, that does not involve any question of change of doctors.

Senator DONNELL. I wasn't talking about a specialist on diabetes. I was talking about a change in doctors. A man might have wanted to change a doctor.

Mr. FALK. But, Senator, that is not what my reference was. What I was addressing myself to in this letter that was sent to Senator Murray, what I said was that the discussion was confusing two separate questions: One, the question of choice and change of doctors, and the other, the question of referral to another doctor or to a specialist.

Now what I am driving at is that in the paragraph you read, we set forth our views in the case of where the physician or the family's particular doctor has chosen to be paid on a capitation payment method. There is need, as far as that is feasible, for the patient to choose his doctor in advance, though he may do it later also.

Senator DONNELL. Pardon me, Mr. Falk. I was referring to a statement, which I can't quote with accuracy, that you made a few minutes ago where, instead of giving us the book and page in your testimony, you were telling us of the general discussion that ranged over 45 minutes or so, as I recall it, in which Dr. Shearon pointed out that where the capitation plan is in effect, the person has to make his selection of a doctor in advance. Then you pointed out that the evidence went into the matter of diabetes, that if you got diabetes, you would have to change and so forth, and the administrative details attached to it. That isn't exactly your language, but it is the point you were developing a little while ago.

In other words, you were indicating, as I understood it, that in that portion of the testimony that Dr. Shearon was pointing out that, if the capitation plan is adopted, the choice of a doctor has to be made in advance of the illness, and that there can arise situations where this would put the patient in a very bad position. Nevertheless, you yourself in this book at page 13, Senate committee print No. 5, point out that "insured persons will be encouraged to select a doctor in advance of actual illness" in cases where the doctors in the communities have chosen to be paid on the capitation basis. So it would seem to me that you and the doctor are pointing out pretty much the same thing to which you were addressing yourself a few moments ago as to what I thought was your suggestion that the doctor was in error in what she said.

Mr. Falk. Senator, I am sorry. My language may not have been clear, because we are talking about two different things.

Senator Donnell. All right.

Mr. Falk. I have not challenged Mrs. Shearon's statement that where the doctor or doctors have or have not, as the case may be, chosen capitation payment, that the patient should be encouraged to choose the doctor in advance.

Senator Donnell. That is a fact.

Mr. Falk. That is a fact, and I am not questioning that, except I would call to your attention that in the paragraph which you read, we also said that if a person failed to make an advance selection, he could, of course, still request the doctor's services when the need arose.

Senator Donnell. Then you go around to the local administrative agency to get the transfer. You point that out in page 14, which is the very thing they called attention to yesterday.

Mr. Falk. Senator, I have not raised that question. I am referring to the situation that no change of doctor or anything like it is involved. When a patient or a family needs the services of a specialist, when it is a question of getting a diabetes expert or a tuberculosis expert or a cardiologist or an internist or a dermatologist, or whatever the patient's need may be, that is simply a question of a referral by the attending physician, the family physician, to the specialist that is indicated, and that is true whether the family physician or attending physician is being paid on a capitation basis, on a fee-for-service basis, a salary basis or any other basis.

The point I am driving at is, from listening to the discussion yesterday, that our views on this subject were misunderstood and which was—I hesitate to use a word which is a very strong word—misrepresented.

Senator Donnell. If you hesitate to say it, Mr. Falk, don't say it. If you think it is just a confusion, don't feel obligated.

Mr. Falk. I am sure that it struck me as being a confusion. I would like to indicate what we said in the same page from which you read—page 14.

Senator Donnell. Senate committee print No. 5?

Mr. Falk. Yes, sir.

Senator Donnell. Very well.

Mr. FALK. This is our document. That is what we said. Following the paragraph that you read, there is a paragraph which isn't pertinent to the point we are considering. Then the next reads as follows:

> Once an insured family has decided it wants a particular physician as its family doctor (or for any member of the family) and has been accepted by him, it will obtain his services just as it would today—according to prevailing practices in the community and the decisions and judgment of the individual doctor (or the medical group if such has been chosen). The doctor will see patients in his office, at their homes or in the hospital, as he does now. Decisions as to the course of treatment will rest entirely with the doctor. Because of the availability of laboratory and related services as insurance benefits, the doctor will be much freer to prescribe laboratory tests or treatments than he is in many cases today, where the family income and ability to pay for such supplementary services has to be taken into account. The general practitioner will also be able to call on specialist and consultant services whenever in his judgment they are needed. He will also be able to prescribe—at the cost of the insurance system rather than of the patient—such special medicines, appliances, etc., as are provided as benefits. Referral to specialists will ordinarily occur through the general practitioner or family doctor, or through a specialist who is already attending the patient; but in case an insured person (or the family of the sick person) is refused a referral which he thinks desirable, he would be able to ask for it through the medical officer of the local insurance office.

Now that, I submit, summarizes our views, and any other view as to the relationship of the patient to the general practitioner, and the relationship to specialists' services, consultant services, or other referral services—anything to the contrary is not our view.

May I also call to your attention that in the colloquy yesterday, it was not brought out that in essence——

Senator DONNELL. Are you still confining yourself to point No. 2 in your letter?

Mr. FALK. Yes.

You, if I remember correctly, read from section 203 of S. 1320, if my memory serves me right, beginning on page 9 of the bill; and you, Senator Donnell, read the first part, which is as follows:

> Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection.

Then, I believe, you read the proviso which follows, which indicates that that must be conditional on the fact,

> That the practitioner, medical group, hospital, or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual.

Then follows a sentence that says:

> General medical and general dental services may be obtained by request made by the individual directly to the practitioner of the individual's choice.

I believe that also was read yesterday. But what follows immediately thereafter was not read:

> Specialist, home-nursing, hospital, and auxiliary services shall be obtained from the specialist, nurse, hospital, or other person of the individual's choice, whenever the practitioner from whom he is receiving medical or dental services as benefits under this title refers him for specialist, home-nursing, hospital, or auxiliary services upon determining that such services are required in the proper care of his particular case; or whenever, upon request of the individual, an administrative medical officer, upon a like determination, refers him for such services.

Then it goes on to say:

> The Board, by regulation, shall dispense with the necessity of referral in cases of emergency, and may dispense with the necessity of referral under specified circumstances or as respects specified classes of services, or both, if it finds, after consultation with the Advisory Council, that such action will be conducive to the provision of more adequate amount and quality of health care and will not unreasonably increase the expenditures from the account for such services.

Now I thought in the discussion yesterday it was clear that section 203 provides that the insured persons who were qualified, that is, had met the insurance test, may freely select the physician, dentist, nurse, etc. I believe it was also clear that that was conditioned upon acceptance of the patient by the practitioner selected by the insured person. It was also clear, I believe, that services may then be obtained by the insured person merely by requesting that service directly from the individual selected; but what was not clear with respect to the bill is that to obtain specialist care, specialist service, or all that is needed under any ordinary circumstances, is that the attending physician or dentist, as the case may be, refer the patient to the needed specialist service; and only, whenever upon request of the individual—that means the insured person here—that specialist service is otherwise desired, is there need, then, to make reference to a medical administrative officer. Furthermore, the whole requirement that specialist services shall be available only by referral from a general practitioner or from another specialist can be dispensed with in cases of emergency and in cases of particular classes of services, if it may be found that in a certain class of service the rules should permit the insured person to go direct to the specialist, rather than having to get to the specialist via the general practitioner.

Senator DONNELL. I think it is quite proper Mr. Falk has called attention to the further provisions in section 203. I think they should receive our careful consideration. I think it is well that you have done that, Mr. Falk. I am glad you have done that.

Mr. FALK. That is the only objective I had here, Senator, to indicate that there was confusion in the discussion yesterday. This is a matter of such great importance and one which has received so much attention in public discussions and in professional groups, that it was very important that it should be clear insofar as I can help make it clear.

Senator DONNELL. I may say in that connection, Mr. Falk, that I think this whole subject matter is one that we must thoroughly explore and consider. I may say also, I think, in fairness to Dr. Shearon, that if such confusion arose, it may well have arisen largely, if not entirely, from the questioning of myself rather than from the testimony of Dr. Shearon. I am not conceding the ultimate conclusions that you arrived at, and I think it is a matter that we want to hear Dr. Shearon on also. Nevertheless, I do not think that she should in any sense be criticized for such errors as any member of the committee—and particularly myself—may make in interrogating witnesses. So I want to make that perfectly clear at this time.

Mr. FALK. Have I time to make one very brief statement about No. 3?

Senator DONNELL. I think, perhaps, Senator Murray, we had better adjourn at this time.

Senator MURRAY. Yes.

Mr. **Falk**. I have only one or two sentences to state on item No. 3, if you wish to have it at this time, Senator.

Senator **Murray**. I could continue.

Senator **Donnell**. Mr. Falk, we would have to obtain consent under the LaFollette Act in order to continue in session this afternoon. I believe that we had better not proceed further. One sentence or two might lead to further questions from myself and possibly Senator Murray. I don't know whether he wants to interrogate you, but I believe we had better not proceed further at this time.

So, unless there is objection from Senator Murray, the committee is in recess, subject only to this point: May we agree that March 1st of this year, at 10 o'clock in the morning, will be the time at which the hearings will resume?

Senator **Murray**. Very well.

Senator **Donnell**. The committee is in recess until the first day of March 1948, at 10 a. m., at which time we shall again convene in this room.

Mr. Falk, we will be very happy to have you proceed further, if you desire to do so at that time. Dr. Shearon likewise will be permitted to testify.

(Whereupon, at 12 noon, February 5, 1948, the subcommittee adjourned until 10 a. m., March 1, 1948.)

(It developed that no further hearings were held until May 25, 1948.)

NATIONAL HEALTH PROGRAM

TUESDAY, MAY 25, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to call, at 11:10 a. m., in the committee hearing room, Capitol Building, Senator Forrest C. Donnell, presiding.

Present: Senator Donnell (presiding).

Senator Donnell. Before entering upon the testimony this morning I offer into the record a statement which Senator Smith has presented to me for inclusion therein. The statement is dated May 25, 1948, and bears upon a matter called to the attention of Senator Smith by Senator Murray, with respect to the record of hearings on Friday, January 30, 1948. The statement by Senator Smith will be incorporated in the record in full.

(The statement referred to follows:)

Statement for the Record by Senator Smith

Senator Murray has called to my attention that in the record of the hearings on Friday, January 30, I made the following statement (page 657):

"Senator Smith. Now wait a minute. Let me just remind you that when Senator Pepper was chairman of the subcommittee a report was made coming from the subcommittee to which my name was added as a member. I had never been called to a meeting. The report was printed saying the committee decided compulsory insurance was the only answer and was circulated before I even saw a copy, and my name was on that.

"Senator Murray. I was not on that committee.

"Senator Smith. That was done and it was compulsory health insurance, and hundreds of thousands of copies were circulated and Senator Donnell protested on the floor about not having a member come in to read the report before it was approved. That was very wrong.

"Senator Murray. That is a matter you can fight out with Senator Pepper. I don't know anything about that.

"Senator Smith. I am just trying to meet the comment that there is no evidence of any attempt being made to try and sell compulsory health insurance by the Government to this country * * *."

Senator Murray has called to my attention that it appears in the Congressional Record for July 24, 1946, on page 9858, and following, in connection with a statement made by Senator Pepper, that a letter appears from me to Senator Pepper acknowledging receipt of the subcommittee report entitled "Health Insurance." Senator Murray is technically correct in this matter, and therefore I was incorrect in my statement that the report was circulated "before I even saw a copy." The report actually was sent to me, but let me point out that while I had not studied the entire report, I strongly protested the conclusions, as did other members of the subcommittee, and the matter was never referred to the full Committee on Education and Labor to pass on.

I am glad Senator Murray brought up the point because it recalls the very extended discussion of the matter, as recorded in the Congressional Record of

July 23, 1946, on page 9701, and running through 9707, where Senator Donnell pointed out very properly that a subcommittee report, which had not even been approved by a majority of the subcommittee, had been circulated and given wide notice in the press before the matter had ever been reported to the full committee.

The evidence at these hearings seems to bring out clearly there has been wide and extensive propaganda by employees of the Government in various departments to "sell" to the country a program for compulsory health insurance.

Senator Donnell. Dr. Shearon, it has been quite a while since we had part of your testimony. I will ask you to bring up such points as you think proper, and if you desire to present any preliminary matters, it will be entirely agreeable that you may do so.

STATEMENT OF MARJORIE SHEARON, Ph. D., DIRECTOR OF THE SHEARON MEDICAL LEGISLATIVE SERVICE, COLUMBIAN BUILDING, WASHINGTON, D. C.—Resumed

Dr. Shearon. Thank you, Senator. The reason I am going into so much detail at this time on these matters is that while it is not, perhaps, so important legislatively, because the Senate will probably not come to any decision this year on this bill, nevertheless, the bill is of great importance and has far-reaching effects, and is appearing in various ways before a number of Senate committees.

Senator Donnell. Which bill are you referring to?

Dr. Shearon. I am referring to S. 1320. That is the bill, or, shall we say, the principle of national compulsion in medical care for the entire population. I wish to refer to the fact that the Finance Committee has been working on the problem of the extension of social security, and the advisory council has already issued one report, on the extension of old-age insurance, and within a week will issue another report dealing with one portion of the omnibus bill for compulsion in this country, namely, cash benefits for total disability. We have not yet had that before this committee, although a bill was introduced in 1943, S. 1050, which was the blueprint omnibus Wagner-Murray-Dingell bill. What we see now, since that blueprint omnibus bill died in committee, is portions of that bill coming up before different committees. So we have S. 1320 before this committee as the compulsory medical care plan.

We have before the Finance Committee consideration of another part of compulsory health insurance, or, perhaps we would better call it compulsory sickness insurance, namely, the cash benefits that would be paid to persons when they are permanently disabled, and another report will probably come to that committee, also on cash benefits for sickness or temporary disability. That is the statement of the over-all plan for benefits for the entire population in the medical care field.

Now, there has been something else—the National Health Assembly, Inc., which was held in Washington from May 1 to 4. There were about 800 delegates who attended.

Senator Donnell. The Assembly, Inc.—that is the corporation?

Dr. Shearon. National Health Assembly, Inc.

Senator Donnell. Incorporated under whose auspices?

Dr. Shearon. It was incorporated by members of Oscar Ewing's staff. It was incorporated by three persons, two of whom are on Oscar Ewing's staff, but not on the Federal pay roll. I think myself that is something that should be looked into.

I have brought to the public attention elsewhere, in the House, the fact that in order to put over this program, a high Federal official incorporated a private nonprofit corporation to raise funds, and obtained those funds from organizations that have long been lobbying in this field, and then set up that private corporation inside the Federal Government, in Federal space, making use of Federal telephones, office space, and staff.

Senator DONNELL. What is the name of that corporation?

Dr. SHEARON. I will give you a copy of the articles of incorporation. It is the National Health Assembly, Inc. This is a copy of the articles filed here in the District of Columbia, with the Recorder of Deeds, on February 17, 1948, the incorporators being Abe L. Savage, Cornelius A. Wood, Jr., who is the treasurer, and Harold N. Marsh. Mr. Savage and Mr. Wood are on the staff of Mr. Ewing, but not on the Federal pay roll, although they are listed like Federal officials in the Federal Security Agency telephone book, so they have a Federal telephone and office, and when you call them, they say "National Health Assembly," but this is a private corporation.

Senator DONNELL. It has its office in Mr. Ewing's office?

Dr. SHEARON. In the Federal Security Agency building.

Senator DONNELL. May I see a copy of that?

Dr. SHEARON. Yes. I would like to introduce that in the record.

Senator DONNELL. It will be copied into the record in full. Let the record show that the certificate of incorporation bears the serial No. 31425, received by the Recorder of Deeds of the District of Columbia on February 17, 1948.

(The certificate of incorporation referred to, follows:)

THE CERTIFICATE OF INCORPORATION OF NATIONAL HEALTH ASSEMBLY

We, the undersigned, all citizens of the United States, and a majority citizens and residents of the District of Columbia, desiring to associate ourselves as a corporation pursuant to the provisions of title 29, chapter 6 of the District of Columbia Code (1940 edition), do hereby certify as follows:

First, the name or title by which this corporation shall be known in law shall be National Health Assembly.

Second, the term for which said corporation is originated shall be perpetual.

Third, the particular business and object of said corporation shall be:

(*a*) To engage in such activity as may facilitate the closing of the gap between the present knowledge of medical science and the organization of the basic services which make this knowledge generally applicable to the people of the several States, the District of Columbia and the possessions of the United States of America, by assembling and disseminating information relating to medical and other studies and research in the fields of health and welfare, and by arranging, sponsoring, conducting, financing and/or participating in the financing of conferences, conventions, and/or other meetings of organizations and of individuals, both public and private, engaged in or interested in activities directed to advancing health and welfare.

(*b*) To cooperate with individuals and organizations, both public and private, and with Federal, State, and international agencies and organizations looking to the correlation, integration and/or aid of studies and research in the field of health and welfare.

(*c*) To provide financial assistance for the study of problems relating to the health and welfare of the people of the several States, the District of Columbia and the possessions of the United States of America.

(*d*) To engage in such other educational public activities as may promote the health and welfare of the people of the several States, the District of Columbia and the possessions of the United States of America.

Fourth, the said corporation shall not engage in any propaganda or other activities directly or indirectly to influence the passage or defeat of any legislation by the Congress of the United States of America or by the legislature of any of the several States or the possessions of the United States of America or of their political subdivisions, or in any manner to solicit contributions to be used for the purpose of directly or indirectly carrying on propaganda or accomplishing the passage or defeat of any legislation by the Congress of the United States of America or by the legislature of any of the several States or the possessions of the United States of America or their political subdivisions.

Fifth, the said corporation shall be without capital stock and shall not be operated for profit. No part of the net income or net earnings of said corporations shall inure, in whole or in part, to the benefit of the members of said corporation or other individuals.

Sixth, the number of trustees, directors, or managers of said corporation for the first year of its existence shall be three.

In testimony whereof, we have this 16th day of February 1948, hereunto set our hands and seal.

ABE L. SAVAGE.
CORNELIUS A. WOOD, Jr.
HAROLD N. MARSH.

Notary for Wood & Savage:
[SEAL] Albert C. Allen.
Notary for Marsh:
[SEAL] Elizabeth Maynard.

Senator DONNELL. Do you know why it was that it was found necessary or advisable to form a corporation?

Dr. SHEARON. Well, Mr. Ewing explained that, saying that he did not have enough Federal funds to carry on this Assembly, and it had not been authorized by Congress, so he set up the nonprofit corporation in order that he might raise funds. And I think it should be a matter of record as to where that money came from.

Senator DONNELL. I notice that among the provisions of the certificate of incorporation is apparently something contrary to the purpose to which you address yourself. The certificate says:

> The said corporation shall not engage in any propaganda or other activities directly or indirectly intended to influence the passage or defeat of any legislation by the Congress of the United States of America or by the legislature of any of the several States or the possessions of the United States of America or of their political subdivisions, or in any manner to solicit contributions to be used for the purpose of directly or indirectly carrying on propaganda or accomplishing the passage or defeat of any legislation by the Congress of the United States of America or by the legislature of any of the several States or the possessions of the United States of America or their political subdivisions.

Do you know, Doctor, whether or not, in fact, the corporation has solicited contributions, notwithstanding this provision of its charter?

Dr. SHEARON. It has solicited funds. Perhaps Mr. Ewing would say they have not been used for propaganda purposes. I point out that it is very interesting that there is that little provision in the articles of incorporation, because the District Code requires no such statement with regard to nonprofit welfare and educational organizations. So that was put in there, presumably, to indicate that there was no lobbying or propaganda work going on, and then they proceed to lobby in a very large way. I think that will be indicated by the sources of funds.

The sources of funds are always extremely interesting, as showing who is controlling, who is doing what. The funds came from—and this was announced by Oscar Ewing, and I confirmed it the other day from six sources—in the total amount of $45,000——

Senator DONNELL. What were the sources?

Dr. SHEARON. From the American Red Cross, American Cancer Society, the Foundation for Infantile Paralysis, the Albert and Mary Lasker Foundation, the Adelaide [Rosenwald] Levy Foundation——

Senator Donnell. Is that the successor of the Rosenwald Foundation in Chicago?

Dr. Shearon. Adelaide Levy is his daughter. That is a fund. And the Milbank——

Senator Donnell. Milbank Foundation?

Dr. Shearon. Fund.

Senator Donnell. The Milbank Fund.

Dr. Shearon. The total is $45,000, of which, up to May 4th, $43,000 had been spent.

Senator Donnell. Do we have any information as to the purposes for which the $43,000 was spent?

Dr. Shearon. Yes, there is some indication, in view of the fact that some of the releases that were sent out in regard to the National Health Assembly, Inc., were presumably paid for out of the fund. There was also a very expensive banquet given at the Statler. The tickets were only $3 and there must have been a subsidy, because the usual price is around $7.

Senator Donnell. Were any Members of Congress present at that meeting?

Dr. Shearon. I do not think so. President Truman was there. I do not recall seeing any Members of Congress, either at the banquet, or at any other time. I do not know that they were invited. Anyway, I did not see any at all.

Senator Donnell. Very well.

Dr. Shearon. I want to say that those last three sources of funds have been the sources which for a long time have been related to this entire movement for the nationalization of medicine. We have had the names coming up time and time again as being the sponsors and backers of Michael M. Davis, who heads the primary nongovernmental lobby for the nationalization of medicine, namely, the Committee for the Nation's Health.

Senator Donnell. Is Abe L. Savage in the office of Mr. Ewing?

Dr. Shearon. Yes, he is in the office, but not on the pay roll.

Senator Donnell. What is his connection with the office, if you know?

Dr. Shearon. He is in charge of publicity.

Senator Donnell. In charge of the publicity of this corporation?

Dr. Shearon. Of the Assembly, that is right.

Senator Donnell. Is he connected in any way with the official office of Mr. Ewing as a Government official?

Dr. Shearon. No.

Senator Donnell. He has his quarters in Mr. Ewing's office?

Dr. Shearon. He and Mr. Wood both.

Senator Donnell. Does he have a desk in the quarters of the Federal Security Agency?

Dr. Shearon. That is right—and a telephone.

Senator Donnell. What is Mr. Wood's position?

Dr. Shearon. He is treasurer of the National Health Assembly, Inc.

Senator Donnell. Does he have any official connection?

Dr. Shearon. No. He told me he was being paid by the National Health Assembly, Inc. However, their funds have been in all of it, and he is still there.

Senator Donnell. Does he have an office in the Federal Security Agency?

Dr. Shearon. Yes.

Senator Donnell. An office, and a desk?

Dr. Shearon. Yes.

Senator Donnell. Physical office space?

Dr. Shearon. Yes.

Senator Donnell. Who is Harold N. Marsh?

Dr. Shearon. He is an attorney in the District. He did not have anything to say. He refused to say anything. He said he had been in at the beginning, at the time of the incorporation, and he had nothing to say. He was very uncommunicative.

Senator Donnell. You referred to the fact that some information had been furnished by you to other committees.

Dr. Shearon. Yes, that is right.

Senator Donnell. What were those committees?

Dr. Shearon. I gave this information, as soon as I had it, to Congressman Harness and Congressman Keefe, it being important at that time, because Congressman Keefe is the Chairman of the House Appropriations Subcommittee that handles funds for the Federal Security Agency. And I might say that Mr. Ewing refused to give any information as to the background of these men. Of course, ordinarily you can get information about a civil servant. The Civil Service Commission had no information about these two men who are there and were listed in the telephone book the same as any other Federal employees.

Senator Donnell. Very well, Doctor, proceed.

Dr. Shearon. I think I should say a little more about that National Health Assembly. The witnesses were invited by the Federal Government.

Senator Donnell. You are referring to the meeting that was held in Washington?

Dr. Shearon. I should not have said "witnesses." The delegates who were invited to that meeting were invited——

Senator Donnell. Doctor, let me get myself and the record clear on that. You are using the term "assembly" in two senses?

Dr. Shearon. Yes.

Senator Donnell. Is the name of this corporation "The National Health Assembly, Inc."?

Dr. Shearon. Yes.

Senator Donnell. Then there was held in Washington an assembly, or convention, or conventions, or gathering—you might call it a convention.

Dr. Shearon. They called it the National Health Assembly, but left off the "Incorporated." I do not believe the public was supposed to know that it was incorporated, so they never used it on their letterheads or anything of that sort.

Senator Donnell. Do you know whether the corporation itself was the manager of the convention, which in turn was called the National Health Assembly?

Dr. Shearon. No; the managing was done, in fact, the thing initiated with Donald Kingsley, who is the Assistant Administrator under Oscar Ewing.

Senator Donnell. You mean this gathering?

Dr. Shearon. It was his idea.

Senator DONNELL. This gathering called the National Health Assembly was initiated by Donald Kingsley?

Dr. SHEARON. That is right.

Senator DONNELL. Who is Donald Kingsley?

Dr. SHEARON. He is the Assistant Administrator to Oscar Ewing.

Senator DONNELL. He is the next man in line to Mr. Ewing?

Dr. SHEARON. The next man in line, that is right.

Senator DONNELL. What was done toward utilizing this corporation in the carrying out of the meeting which was held in Washington and called the National Health Assembly?

Dr. SHEARON. I think primarily they simply used the funds and the preparation was not very visible except insofar as these people helped to run the meeting.

Senator DONNELL. This $45,000—you have ascertained that was contributed by these six organizations to the corporation; is that right?

Dr. SHEARON. That is right, and Mr. Ewing gave that information at a press conference. I have since confirmed it with the treasurer, Mr. Wood, this past week.

Senator DONNELL. Of that $45,000, approximately $43,000—

Dr. SHEARON. Had been spent by May 4.

Senator DONNELL. Was the bulk of that spent on or in connection with the holding of this conference called the National Health Assembly?

Dr. SHEARON. That is what Mr. Ewing stated in the press conference.

Senator DONNELL. All right. Go right ahead.

Dr. SHEARON. When this whole thing was planned, they originally picked out 24 persons for a top executive steering committee. I might say that it was not in any way a representative meeting of health experts in this field. I should say it was more politically picked than picked for professional competence.

Senator DONNELL. What was that group to do?

Dr. SHEARON. That was the top steering committee. It was a policy committee called the Executive Committee.

Senator DONNELL. The policy committee of the gathering?

Dr. SHEARON. Of the gathering, and they were to decide on matters of policy.

Senator DONNELL. The committee consisted of 24 persons?

Dr. SHEARON. Yes.

Senator DONNELL. Do you have a list of those 24 persons.

Dr. SHEARON. If I do not have it here, I might say I have three books full of material on the National Health Assembly. I just did not carry them all here. I can give you that list. It was later expanded to 39, I think, after a great deal of complaint went up that the original list was not representative of the health professions of the country. For instance, it had only one doctor of medicine. Yes, I have the committee here in the beginning.

Senator DONNELL. Will you please give us that for the record?

Dr. SHEARON. I might point out that it was not at all equitably chosen, and that it did contain what I might call a preponderance of persons who were already committed to the enactment of the Wagner-Murray-Dingell bill.

When it was first announced, this Executive Committee, there was considerable protest about the way in which it had been selected, and there were subsequent changes and additions to bring it up to 39. I have here the augmented list and I should like to send in the original list for the record.

Senator DONNELL. At this point the original list will be inserted in the record. Would you also file the list of 39?

Dr. SHEARON. Yes.

Senator DONNELL. Very well, it will be received and incorporated in the record at this point.

(The lists referred to follow as submitted:)

EXECUTIVE COMMITTEE MEMBERS

NATIONAL HEALTH ASSEMBLY

FEBRUARY 13, 1948

Mr. Barry Bingham, editor and president, Louisville Courier-Journal.
Mrs. J. L. Blair Buck, president, General Federation of Women's Clubs.
Mr. Earl Bunting, president, National Association of Manufacturers.
Miss Elisabeth Christman, secretary-treasurer, National Women's Trade Union League.
Dr. Louis I. Dublin, second vice-president and statistician, Metropolitan Life Insurance Co.
Judge Jerome N. Frank, U. S. Circuit Court of Appeals.
Mr. Albert S. Goss, president, National Grange.
Mr. William Green, president, American Federation of Labor.
The Most Rev. Francis J. Haas, Bishop of Grand Rapids, Grand Rapids, Mich.
Miss Frieda Hennock, New York City.
Mrs. L. W. Hughes, president, National Congress of Parents and Teachers.
Mr. Eric Johnston, president, Motion Picture Producers & Distributors of America.
Mr. Allan Kline, president, American Farm Bureau Federation.
Mrs. Mary Lasker, New York City.
Mrs. David Levy, New York City.
Dr. George F. Lull, secretary and general manager, American Medical Association.
Mrs. Eugene Meyer, Washington, D. C.
Mr. Philip Murray, president, Congress of Industrial Organizations.
Mrs. Anna M. Rosenberg, New York City.
Mr. Earl O. Shreve, president, U. S. Chamber of Commerce.
Dr. Frank Stanton, president, Columbia Broadcasting System, Inc.
Mr. M. W. Thatcher, president, National Federation of Grain Cooperatives.
Mr. Walter White, secretary, National Association for the Advancement of Colored People.
Dr. Abel Wolman, consulting engineer, Johns Hopkins University.

(Above list released by Federal Security Agency for Sunday, February 15, 1948 on Release FSA-333)

NATIONAL HEALTH ASSEMBLY

WASHINGTON, D. C.

MAY 1-4, 1948

EXECUTIVE COMMITTEE

Rev. John W. Barrett, vice-president, Catholic Hospital Association.
Mr. Barry Bingham, editor and president, Louisville Courier-Journal.
Dr. Edward L. Bortz, president, American Medical Association.
Rev. Beverley M. Boyd, executive secretary, Department of Christian Social Relations, Federal Council of the Churches of Christ in America.
Mrs. J. L. Blair Buck, president, General Federation of Women's Clubs.
Mr. Earl Bunting, president, National Association of Manufacturers.
Miss Elisabeth Christman, secretary-treasurer, National Women's Trade Union League.

Mr. John W. Dargavel, executive secretary, National Association of Retail Druggists.
Mr. Graham L. Davis, president, American Hospital Association.
Dr. Robert P. Fishchelis, secretary, American Pharmaceutical Association.
Judge Jerome N. Frank, U. S. Circuit Court of Appeals, New York.
Dr. Vlado A. Getting, president, Association of State and Territorial Health Officers.
Mr. Albert S. Goss, president, National Grange.
Mr. William Green, president, American Federation of Labor.
The Most Rev. Francis J. Haas, Bishop of Grand Rapids, Mich.
Dr. Paul R. Hawley, chief executive officer, Blue Cross Hospital Service and Blue Shield Medical-Surgical Service (as of Apr. 1, 1948).
Miss Frieda Hennock, New York City.
Dr. Harold Hillenbrand, general secretary, American Dental Association.
Mrs. L. W. Hughes, president, National Congress of Parents and Teachers.
Mrs. Katherine Densford, president, American Nurses' Assoc.
Dr. Louis I. Dublin, second vice president, Metropolitan Life Insurance Co.
Mr. Eric Johnston, president, Motion Picture Producers and Distributors of America
Mr. Allan Kline, president, American Farm Bureau Fed.
Mrs. Mary Lasker (member of Lobby Committee for Nation's Health), New York City.
Mrs. David Levy (member of Lobby Committee for Nation's Health), New York City.
Dr. George F. Lull, secretary and general manager, American Medical Association.
Mrs. Eugene Meyer, Washington, D. C.
Dr. James L. Morrill, University of Minnesota.
Mr. Philip Murray, president, Congress of Industrial Organizations.
Mr. James G. Patton, president, National Farmers Union.
Mr. William Harding Jackson, chairman, Hospital Council of Greater, N. Y.
Mrs. Anna M. Rosenberg, (member of W-M-D. Lobbying Group Committee for Nation's Health), New York City.
Dr. R. L. Sensenich, president-elect, American Medical Association.
Mr. Earl O. Shreve, president, Chamber of Commerce of U. S. A.
Dr. Frank Stanton, president, Columbia Broadcasting System, Inc.
Mr. M. W. Thatcher, president, National Federation of Grain Cooperatives.
Hon. Jerry Voorhis, general secretary, Cooperative League of U. S. A.
Mr. Walter White, secretary, National Association for the Advancement of Colored People.
[1] Dr. Charles F. Wilinsky, president-elect, American Public Health Assoc.
[1] Dr. Abel Wolman, chairman, Executive Board, American Public Health Assoc.

---

[1] This organization is on record as favoring enactment of W-M-D bill. One of their employees, Howard M. Klein, is the executive secretary of the National Health Assembly and is listed in F. S. A. telephone book as on Ewing's staff, but he is not on Federal pay roll.

Dr. SHEARON. Now the assembly had 14 sections and about 800 invited delegates. It is significant to note that 220 of the invited delegates were invited for the medical care section, to deal with compulsory insurance and also with voluntary methods. I have not finished my analysis of these invited delegates, but I have had this much to say about them: They were picked in a most peculiar fashion, to be sure to include plenty of representatives of the two lobby groups, namely, the Physicians' Forum, and the Committee for the Nation's Health. In other words, it was not representative and it was not democratic.

Senator DONNELL. Was Dr. Channing Frothingham on the committee?

Dr. SHEARON. Yes.

Senator DONNELL. Was Dr. Ernst P. Boas on the committee?

Dr. SHEARON. He certainly was. I have not identified them all yet, but at least 13 of the invited delegates were from the Physicians' Forum, which was all out of line in the manner of selection of a fair number of delegates. There were 20 State medical societies that were not represented at all. If they asked to be represented they were turned down. And yet there could be at least 13 representatives of the Physicians' Forum invited, and some rather extraordinary individuals who have a long record of intention to overthrow the United States Government. I refer particularly to Bernard J. Stern.

Senator Donnell. Who is Bernard J. Stern?

Dr. Shearon. He is on the faculty of Columbia University.

Senator Donnell. What does he teach?

Dr. Shearon. That I do not know. It might be sociology, it might be economics. He has been associated with Communist-front organization for years, and at this point I might insert here a part of the record about him. He has been cited some 35 times by the House Un-American Activities Committee. I refer particularly to a call which he signed in 1935, to call a conference of the American Revolutionary Writers, and I might say they are not of the American Revolution, but of the revolution to overthrow America. That call stated—I would like to quote exactly what is stated:

> The capitalistic system crumbles so rapidly before our eyes, that whereas 10 years ago scarcely more than a handful of writers was sufficiently foresighted and courageous to take a stand for proletarian revolution, today hundreds of poets, novelists, dramatists, critics, and short-story writers and journalists recognize the necessity of personally helping to accelerate the destruction of capitalism and the establishment of a worker's government.

That was signed by Bernard J. Stern in 1935, at which time an organization called—I am afraid I will have to provide that name—it is the League of American Writers, which was formed at that time, Bernard J. Stern being a member. Through the years he has been associated with one group after another that is working for the overthrow of this Government, working directly with avowed Communists or with Communist-front organizations.

He was an invited delegate. I have the list here of 220 invited delegates. It seems that they must have gone out of their way to pick a man like that. They also invited a man by the name of Julius Emspack, general secretary-treasurer of the United Electrical Workers. He also has a long record with the House Un-American Activities Committee, and is regarded as one of the most dangerous foreign agents in the country, and it has been stated that he is a communist. I think he was so cited by the Communist Eisler.

I mentioned two of these persons who were invited, and the inviting was done, I understand, primarily by a member of the United States Public Health Service, who selected the names. I suppose he had considerable help because I am sure he would not have thought these up of his own volition. But it is a very peculiar list. I have analyzed it to some extent in order to point out this great peculiarity. We have seen over and over again at these hearings and at other hearings that this movement heads up in New York, the District of Columbia, Massachusetts, and Pennsylvania. I said 220 delegates were invited. Forty-nine were from New York, 41 from the District of Columbia, 14 from Massachusetts, and 18 from Pennsylvania.

Senator Donnell. That would be 142 out of 220.

Dr. Shearon. That is right, 55 percent. It was not a representative meeting. It was stacked, just the same as many other things we have seen at these hearings have been stacked by the same group.

Senator Donnell. Was there somebody present from every State in the Union?

Dr. Shearon. Oh, no. There were 20 States that had nobody present from them at all.

Senator Donnell. Do you know whether anybody was invited from those 20 states?

Dr. Shearon. This is a list of the invited delegates.

Senator Donnell. And there is nobody included from 20 States?

Dr. Shearon. That is right. I have listed here, Senator, the States from which these delegates were invited. I know, for instance, one State medical society, the Louisiana State Medical Society, asked if they could have a delegate's pass, and they were notified by Mr. Ewing that all hotel space was scarce and it was difficult to get meals. They wrote back that they did not care about their bed and board, that they wanted a delegate's pass and they would take care of the rest. But they did not get the pass any more than I did. They came in on a press pass, and, of course, could not take part in the discussion. The meeting was not one wherein free and open discussion was had. I have never attended a meeting before where there was no free and open discussion from persons from the floor. But the only persons who could discuss the papers——

Senator Donnell. May I interrupt, Doctor? The 220 persons to whom you refer as being invited, were invited to this one particular section, that is, the Medical Care Section?

Dr. Shearon. That is correct. That was the main thing. It looked as if the whole assembly had been called around that one section. That was the major section.

Senator Donnell. Seven hundred persons were invited?

Dr. Shearon. Seven to eight hundred.

Senator Donnell. Seven or eight hundred were invited to the entire assembly, and of the seven or eight hundred, 220 were invited to the section on medical care?

Dr. Shearon. Yes.

Senator Donnell. And of the 220, they did not include 20 of the States of the Union?

Dr. Shearon. That is right.

Senator Donnell. I observe in this paper which you have handed me, marked "American Medicine and the Political Scene," volume 2, No. 15, copyright by The Shearon Medical Legislative Service—that is your organization?

Dr. Shearon. Yes.

Senator Donnell. The article states: "The South, Far-West, and Rocky Mountain areas were, as usual, left out in the cold."

Dr. Shearon. That is right.

Senator Donnell. I notice Arkansas does not seem to be in here, and I do not see Iowa.

Dr. Shearon. No.

Senator Donnell. Nebraska does not seem to be here. Very well, go right ahead, Doctor. I hand you back the paper.

Dr. Shearon. I do not know that I care to say any more, but I do want to point out that here was an assembly called in a peculiar way, financed, in part, at least, by the financers of the Committee for the Nation's Health. There was no free discussion from the floor, in other words, you could not speak or make a comment on a paper unless you were an invited delegate.

Senator Donnell. Did this assembly, that is to say, the gathering, adopt any resolutions?

Dr. Shearon. Yes.

Senator Donnell. Were any of those resolutions by their terms to be called to the attention of the Congress?

Dr. Shearon. Oh, yes; this is what they were doing. At the end of each section, they brought out a series of statements as to goals, and what they thought we should do for the next 10 years.

Senator Donnell. Did any of those resolutions say by their terms that they were to be called to the attention of the Congress, or, is any one directed to the Congress?

Dr. Shearon. Presumably, President Truman will do that. The procedure is this: These recommendations have gone in and are now being studied by the Federal officials who are on the Federal pay rolls. The National Health Assembly, Inc., seems to have passed out from being a private corporation, to being a part of the Federal Government.

Senator Donnell. Doctor, am I correct in this understanding, that a corporation which by the terms of its charter is not to engage in any propaganda or other activities directly or indirectly intended to influence the passage or defeat of any legislation by the Congress of the United States of America or by the legislature of any of the several States or the possessions of the United States of America or of their political subdivisions, that that corporation was financed by six contributors to the tune of $45,000, of which $43,000 was spent, the major part of it, for this assembly? And that then the assembly engaged in the adoption of resolutions which are in turn under consideration by Departments of the Government, and in your judgment will probably be the basis, in part, at any rate, of an expression by the President of the United States to the Congress? Is that right? Am I correctly stating it.

Dr. Shearon. You have carried it one step further when you say the President will say something to Congress. That, I do not know. That would be an assumption on your part and mine.

Senator Donnell. You would not know, but that is your surmise?

Dr. Shearon. That would be the surmise.

Senator Donnell. That the Federal Security Agency will advise the President, through the medium of the information and resolutions, respectively, obtained and passed by the corporation, which was financed by these funds to which you refer, and which corporation by its terms is distinctly stated to be prohibited against engaging in propaganda intended to influence the passage or defeat of legislation?

Dr. Shearon. That is entirely correct. Now, I might say, Mr. Ewing stated that he was going to make a report to the President, and that he would not necessarily be bound by the findings of the National Health Assembly, nor yet by the recommendations of the top executive committee. He was going to make his own report, in other words. On the other hand, when he was pressed to speak on the many things he would bring out he said, well, he was not ready to say anything yet. This was on May 4. He was not ready to say anything until the reports from the various sections had been gone through. He expected to make this report to the President early in June.

Senator Donnell. Did he attend the gathering himself?

Dr. SHEARON. Yes; he attended the gathering and he said most of the credit for the running of the Assembly—and it was a very large assembly, of course, as you can imagine, with that many invited delegates—of course some did not accept but there were many guests—it was a very large meeting, and he said it had been run primarily by Donald Kingsley, who is entirely full time on the Federal pay roll, and another man I have not mentioned, Howard M. Kline, who is the executive secretary of the National Health Assembly. He is not now on the Federal pay roll but he was. He was in the Public Health Service during the war, until the war was over, then he got out of the Public Health Service and went with the American Public Health Association, which itself has a platform——

Senator DONNELL. Doctor, have you seen the Journal of the American Medical Association of May 3, 1948, particularly an article entitled "The National Health Assembly"?

Dr. SHEARON. Yes; I have. That was written by a man who is the editor of the Journal, presumably, and represents one man's opinion. It does not represent the opinion of the doctors of this country. I am quite sure there is considerable discussion behind the scenes, that that type of editorial should occur.

Senator DONNELL. It is entitled "National Health Assembly."

Dr. SHEARON. Yes; that is right. This is an inexplicable editorial and it is causing considerable trouble behind the scenes inside the medical profession.

Senator DONNELL. I think it might be well to have this in the record, so we might have that opinion for discussion. It will be placed in the record at this point—an editorial from the Journal of the American Medical Association under date of May 3, 1948.

(The editorial referred to follows:)

[Excerpt from the Journal of the American Medical Association, May 3, 1948]

THE NATIONAL HEALTH ASSEMBLY

The National Health Assembly which heralded the beginning of May in Washington, D. C., established what is apparently a new record for such conferences. Definite efforts were made to ascertain points of view, to attach proper weight to each of them, and on the basis of the evidence submitted, to propose recommendations which might be considered objectives or goals in advancing health during the next ten years. Previous conferences have been suspect of having propaganda in behalf of certain proposals leading to legislation as their prime motivation. If that was the original intent of the National Health Assembly of 1948, and it seemed to be such when the proposed assembly, its financial supporters and executive committee were announced a few months ago, the subsequent developments and the final action taken have resolved the doubts and anxieties. For this credit should be assigned perhaps to Mr. Ewing and his associates, notably Dr. Howard Kline, who evolved from the original executive committee of twenty-four members with only one physician a final committee aggregating thirty-nine with official representation for the American Hospital Association, the American Dental Association, the conference of State and Provincial Health Officers, the American Medical Association and similar bodies. On this executive committee will fall the final responsibility for evaluating the recommendations that come from the different panels or sections and for issuing a final statement to clarify objectives in health for the people of the United States.

Between 700 and 800 interested members of almost every agency in the United States concerned even remotely with health registered in the assembly. At least half of them were enrolled in sections devoted to such topics as medical personnel, local health units, research, nutrition, maternal and child health, chronic diseases and age, medical care and other significant classifications.

These sections held four or more meetings in which opportunity to speak was given to any of those who wished to be heard on the subject of their own experiences or their criticisms of the opinions and experiences of others. As might be anticipated, panaceas, short-cuts, regimentations and revolutions were offered as solutions of the problems in the advancement and development of medical services. The bizarre and weird recommendations of radical proponents for remaking our system of medical care fell by the wayside. The recommendations of the steering committees in the individual panels seemed likely to yield technics for steady and continuous progress in meeting our medical needs.

In subsequent issues of the Journal the reports of each of the panels will be made available. The recommendations may be given consideration by the appropriate councils, committees and bureaus of the American Medical Association and by the House of Delegates, which will speak for the American Medical Association as to the policies considered acceptable.

Fortunately in this assembly, as contrasted with the National Health Conference of 1938, the American Medical Association was represented by competent experts in each of the fields concerned. Several members of the council on medical service participated in the panel on medical care. Chairmen in several sections, notably maternal and child health, research, local health units, medical care, physical medicine, hospital facilities and mental health were distinguished Fellows of the American Medical Association. Members in adequate numbers served on the panels devoted to rural health, community organization, public health, hospitals, personnel and environmental sanitation. The Association had available, moreover, its public relations and publicity staff and additional members on the executive committee. The President of the American Medical Association and the Editor of the Journal spoke before meetings of the entire assembly. The president-elect, members of the board of trustees and of the various councils addresed the individual sections.

Clearly apparent from the first note sounded by Mr. Oscar Ewing in his opening address was recognition of the fundamental importance of a high quality of medical education for the solution of every medical problem. Second in emphasis was the necessity for consumer and professional cooperation in the development of adequate medical care at costs within the range of the mass of the people. Third was a perception of the necessity for continued experimentation in the development of technics of providing and distributing medical care suitable to the needs of a diversified population under varying economic conditions. Fourth was emphasis on the special problems of the Negro physician and the Negro patient. Such corollary questions as the availability of animals for experimentation, of funds for conducting the medical schools and research institutions on a high plane, hospitalization and health centers, technics of transportation of the sick for rural areas, cooperatives for health, group practice, medical insurance on a service or fee-for-service basis and elimination of the profit motive in prepayment plans developed extended discussion and indicated the need of more study by experts.

Dr. SHEARON. In that case, I should like to have introduced in the record my own statement, which I do not have with me, which appears on May 28 in the American Medicine and Political Scene, commenting on the fact of this editorial.

Senator DONNELL. When received, that will be placed in the record in full at this point.

Dr. SHEARON. It might interest you, as it interested me.

(The statement of Dr. Shearon referred to is as follows:)

[Excerpt from American Medicine and the Political Scene, vol. II, No. 17, p. 4]

DR. FISHBEIN SENDS CONGRATULATIONS TO EWING ON SUCCESS OF HEALTH ASSEMBLY

Oscar R. Ewing, Federal Security Administrator, is making considerable capital out of a telegram which he received from Morris Fishbein. On May 8 Ewing sent out an official, franked, Federal Security Agency release to the newspapers in which he stated that "his office is still receiving congratulatory messages on the success of the National Health Assembly. * * *"

According to the release Mr. Ewing said the Asembly, which he called following the President's request to him to draw up a 10-year program of national-health goals, had exceeded in effectiveness "our most optimistic hopes." He stated that work is in full swing on his forthcoming report to the President, which will embody this 10-year plan. The report, he added, should reach the President early in June.

Among the telegrams quoted in this release was one from Morris Fishbein stating:

"Again my sincere congratulations on the best meeting of its kind I have ever attended in Washington. Please send me full particulars on availability of complete reports for publication."

KINGSLEY ADMITS HE WROTE PRESIDENT'S LETTER THAT LED TO CALLING NHA, INC.

The Ewing version of how the Assembly came to be called is untrue. On May 12, 4 days after the press release cited above, Donald Kingsley, Assistant FSA Administrator, was compelled to give the true version at the Senate appropriations hearings when Senator Ball asked him who really wrote the letter which Ewing said the President had written. Kingsley, when pressed by the Senator, admitted that he himself had written "the President's letter." That fact has not been publicized.

I cannot myself see any great cause for congratulating Ewing on the NHA, Inc. It was financed by supporters of nationalization; only invited delegates could discuss papers; delegates were selected for political and propaganda purposes. The final recommendations that came out of the Medical Care Section were said by Nelson Cruikshank of the AFL to be a virtual endorsement of the principle of national compulsory health insurance. Only under national compulsion could the entire population be covered in the ways specified in the final recommendations for national goals.

Senator DONNELL. I observe, if I may interrupt for a moment, in the course of this editorial from the Journal of the American Medical Association, this statement, referring to the address of President Truman at the banquet:

> President Harry S. Truman, the only speaker at the opening banquet, indicated again his concern over the health problems of the Nation and his continued conviction that a compulsory sickness insurance system is an acceptable solution. By far the majority of representatives of the medical profession present could not concede on this point. The voices raised in support of this contention were the same old, and now somewhat weary, voices of the Physicians' Forum, Committee on the Nation's Health, the economists of the national headquarters of the A. F. of L. and the CIO. When the tumult and the shouting died, the record seemed to indicate that the Blue Cross hospitalization plans, the nonprofit voluntary prepayment plans, the cooperatives, the group health associations, the private agencies and other forms of organization for the delivery of medical services had enrolled millions and millions of people. While there were still knotty problems not yet unraveled and areas of insufficiency not yet supplied, the Nation seemed to be on the way toward the development of a plan for the production and distribution of medical services suitable to the American democracy.

Do you care to comment on that statement in that editorial?

Dr. SHEARON. Yes; I certainly am entirely in accord with a part of the editorial. President Truman did say he was in favor of compulsory insurance, and Mr. Ewing himself also made that statement. I think the way in which they got around the lobbying law was the same way Michael Davis did. He got up time and again and said "We are not mentioning any bills by name. We just favor compulsory insurance."

Of course, there has only been one bill before Congress—I mean, one series of bills relating to compulsory medical insurance, and that is the Wagner-Murray-Dingell series of bills. So you do not have to mention it by name, when there is only one name. When you come out in favor of it, in my opinion, you would be lobbying for that bill.

Senator DONNELL. Do you know, Doctor, if there was a stenographic report taken of the proceedings of the Assembly?

Dr. Shearon. Yes.

Senator DONNELL. Including the remarks of Mr. Davis?

Dr. SHEARON. Yes. There was in the section I was. And I assume there was in the other section. The Assembly was very well organized. It was a beautiful job from the point of view of organization.

Senator DONNELL. Do you know whether or not a report which has been available for distribution was prepared for circulation showing the proceedings in full?

Dr. SHEARON. I do not know that they will do that. They put out short so-called factual statements each day in regard to the discussions, just a line or so, in regard to who did discuss papers and the gist of what was said. It was a little digest. But the total transcript, I imagine, would be terribly expensive.

Senator DONNELL. All right. Go ahead.

Dr. SHEARON. I just want to show you these two envelopes. One, we received before the Assembly, postmarked April 22, 1948, a National Health Assembly envelope.

Senator DONNELL. Bearing in typewriting above the name "National Health Assembly" the name "Abe L. Savage" postmarked "Washington Apr. 22," bearing canceled stamps, and addressed to "Marjorie Shearon, 610 Columbian Building, Washington, D. C." Did you receive something in that envelope?

Dr. SHEARON. I received material about the National Health Assembly. Now, however, after the Assembly is over, I receive it under Government frank.

Senator DONNELL. The information to which Dr. Shearon now refers is an envelope postmarked "Washington, D. C. May 7, 1948. 8:30 p. m.," the language on the envelope, in addition to the postmark, being "Federal Security Agency, Office of the Administrator, Washington 25, D. C., official business"—"Penalty for Private use to avoid payment of postage, $300:" "(PMGC)", then the usual savings bond admonishment. It is addressed to "Marjorie Shearon, American Medicine and Political Science, 610 Columbian Building, Washington, D. C."

Doctor, were you one of the persons selected as a delegate? Were you invited, or how did you attend?

Dr. SHEARON. I certainly was not. I did not ask to go, but certain organizations in the country asked that I go because of my knowledge of this field.

Senator DONNELL. Did you go as an observer, or were you ultimately invited as a delegate?

Dr. SHEARON. I was not invited as a delegate. As a matter of fact, Senator Brooks' office tried very hard to get me in until the last minute. They finally got Mr. Ewing on the telephone. He said he wouldn't let me in because I put out this "scandal sheet," "American Medicine and the Political Scene."

I would like to observe that I am sorry if the actions of a Federal official are such that when I describe him he feels that my paper, in which I describe him, is a scandal sheet.

I presented the facts about what Mr. Ewing did in connection with this Assembly, and I somewhat resent my sheet being called a scandal sheet because I have been frank. Anyway, that was his observation, and I finally got in on a press pass, which did not permit me to speak for even 5 minutes, but Bernard J. Stern, who is seeking to overthrow our Government, spoke repeatedly.

Senator DONNELL. Doctor, you are recognized throughout the Nation among medical societies as a student of this compulsory insurance problem, and have been invited to address and have addressed numerous organizations of doctors in widely scattered sections of the country, have you not?

Dr. SHEARON. Yes.

Senator DONNELL. And certainly it has been perfectly clear in the record in this testimony from time to time that you have been deeply interested in and are a profound student of these subject matters. Mr. Falk knows you well, as has been previously testified to here; that is correct, is it not?

Dr. SHEARON. Yes; that is correct.

Senator DONNELL. Yet, you were not invited to attend this gathering?

Dr. SHEARON. And, I might say, repeated efforts were made by several groups communicating directly with Mr. Ewing. He entirely ignored the letters.

Senator DONNELL. You may go ahead.

Dr. SHEARON. That is all I care to say on that. I think it is significant, in view of the fact that we have legislation before Congress, and that at the National Health Assembly the President of the United States said he hoped legislation would be passed, not mentioning the bill by name, and Mr. Ewing, himself, stated he was in favor of compulsory insurance. If that is not lobbying, I do not understand the meaning of the word.

There is one other thing which I think is important, which has come up since then. The House Appropriations Subcommittee which handles the Federal Security Agency's appropriation bill, recommended——

Senator DONNELL. Doctor, just a minute. You referred to wanting to introduce something you did not have here. You handed me by request a while ago a copy of American Medicine and the Political Scene, of May 7, 1948. Is it agreeable to you that this also be inserted in the record?

Dr. SHEARON. Yes.

Senator DONNELL. I will cause that to be inserted in full, and the other document to which you referred, another issue.

Dr. SHEARON. A later issue.

Senator DONNELL. An issue of approximately the same size as this?

Dr. SHEARON. Exactly the same.

Senator DONNELL. The edition of May 7 will be introduced at this point.

(The document referred to follows:)

AMERICAN MEDICINE AND THE POLITICAL SCENE

Vol. II, No. 15 May 7, 1948 80th Congress, second session

NATIONAL HEALTH ASSEMBLY, INC., TURNS OUT TO BE POLITICAL SCHEME AS PREDICTED

The National Health Assembly, Inc., developed into a cruel hoax. The gullible, the trusting, and the cooperative were hoodwinked. Some sections, no doubt, were fairly planned, but the Government had its lobbyists planted rather widely throughout the assembly. The willful little group engaged in nationalizing medicine seldom invades scientific groups dealing with geriatrics, nutrition, and chronic diseases. They concentrate on medical and hospital care.

Of 700 delegates, 220 were invited to the section on medical care. Such a motley group has seldom been assembled in one place since the Tower of Babel. Except for a scattering of professional persons—a few physicians, actuaries, insurance men, and scientists, the room was crowded with union representatives and foreign-born or foreign-thinking organizers.

Scattered throughout the delegates were the Government lobbyists: A. J. Altmeyer, I. S. Falk, Wilbur Cohen, Barkev Sanders, Margaret Klem, and Harry N. Rosenfield. Most of the engineering of arrangements in the medical care section was done by Michael M. Davis, chairman of the executive committee of the Committee for the Nation's Health, and by Peggy Stein, Washington representative of that organization. Miss Stein, Nelson Cruikshank of the AFL, and Rosenfield, a Federal employee on Ewing's staff, worked as a team as they have done at the Senate health hearings. One could not feel that the Medical Care Section was a bona fide meeting of men of good will. Instead, one was conscious at all times of the machinations of the lobbyists from the Committee for the Nation's Health and from the Physicians Forum.

INVITED DELEGATES TO NHA, INC., WERE CHOSEN ON UNDEMOCRATIC BASIS

Dr. Hugh Leavell, Professor of Public Health Practice, Harvard School of Public Health, was the Chairman of the Medical Care Section. He presided with dignity and fairness under most trying circumstances.

The list of invited delegates to this section numbered 220, distributed as follows:

Alabama	3	Kentucky	2	North Carolina	2
California	8	Maryland	6	North Dakota	1
Canada	1	Massachusetts	14	Ohio	7
Colorado	4	Michigan	8	Oklahoma	2
Connecticut	2	Minnesota	3	Pennsylvania	18
Delaware	1	Missouri	7	Texas	1
District of Columbia	41	Montana	1	Virginia	4
Illinois	12	New Jersey	7	Washington	2
Indiana	5	New Mexico	1	West Virginia	1
Kansas	1	New York	49	Wisconsin	6

Delegates appear to have been chosen from among four groups: Minorities, labor unions, organizations known to be in favor of enactment of the Wagner-Murray-Dingell bill, and the health and medical professions.

Among the invited delegates were approximately 60 physicians, of whom fewer than 10 are in private practice. The Physicians Forum had 7 delegates; some unions had 2 or more. The Louisiana State Medical Society and other medical groups were refused invitations.

The geographical selection of delegates followed the customary pattern, the overwhelming majority being from New York (49), District of Columbia (41), Pennsylvania (18), and Massachusetts (14). These four jurisdictions accounted for 122 delegate invitations (55 percent). Twenty States had no representation. The South, Far West, and Rocky Mountain areas were, as usual, left out in the cold.

EWING INVITED WELL KNOWN COMMUNIST FRONT WRITER BUT SPURNED REPRESENTATIVES OF MEDICAL ORGANIZATIONS

While large professional groups were being denied even a single representative at NHA, Inc., Oscar Ewing was inviting persons whose disloyalty to the United States is a matter of record. One of these delegates was Julius Emspak, United Electrical Workers, who was identified at House hearings as the dangerous foreign agent "Juniper." Another was Bernhard J. Stern, Ph. D. of Columbia University who has been cited more than 35 times in the reports on Communist-front Organizations, published by the House Un-American Activities Committee.

In 1935 the Congress of American Revolutionary Writers was called in New York City and the League of American Writers was founded. The latter has been called a Communist subsidiary whose policies always parallel those of the Communist Party. The Attorney General has declared that this league was founded under Communist auspices in 1935," and the House Committee on Un-American Activities identified the group as a Communist front in 1940, 1942, and 1944. Bernhard J. Stern and the avowed Communists, Earl Browder and Langston Hughes, signed this call to the Congress of American Revolutionary Writers, which stated:

"The capitalist system crumbles so rapidly before our eyes that, whereas ten years ago scarcely more than a handful of writers were sufficiently far-sighted and courageous to take a stand for proletarian revolution, today hundreds of poets, novelists, dramatists, critics, short story writers and journalists recognize the necessity of personally helping to accelerate the destruction of capitalism and the establishment of a workers' government."

The call further declared that there were being invited to the Congress of American Revolutionary Writers those who did not need to be convinced of the decay of capitalism, of the inevitability of revolution. Stern in 1935 was one of those. Despite his record he was an invited delegate to the National Health Assembly, Inc., in 1948. He wrote four of the twelve volumes in the series on American Medicine and the Changing Order for the New York Academy of Medicine. The Academy discovered its error too late. He has testified in favor of the Wagner-Murray-Dingell bill.

FOR THIS AMERICANS CONTRIBUTE THEIR DOLLARS AND DIMES

I have already in previous issues (Vol. II, Nos. 12, 13, and 14) shown how Ewing endeavored to get around the Federal lobbying laws by having the National Health Assembly set up as a private, nonprofit corporation. It is authorized to raise funds, but by its articles of incorporation it may not engage in lobbying activities. However, the whole Assembly was a gigantic lobby for civil rights legislation, compulsory insurance, and the rest of the President's program.

The sources of funds for NHA, Inc. are: The Rosenwald Fund, the Milbank Fund, the American Red Cross, the American Cancer Society, the National Foundation for Infantile Paralysis, and the Albert Lasker Foundation. (Lasker is a backer of Mike Davis' lobbying outfit, the Committee for the Nation's Health which virtually ran the medical care section.) Thus far funds from these sources amount to $45,000 of which $43,000 have been spent.

It will be recalled that I pointed out on April 23 that Ewing had housed the NHA, Inc., a private corporation, in the Federal Security Building. Federal floor space, which is at a premium, was assigned to this private corporation. Federal telephones were used by Howard M. Kline, Abe Savage, and Cornelius Wood although they were not Federal employees. They were listed in the April 1948 telephone book of the Federal Security Agency as being on Oscar Ewing's staff. These three men so far as I can learn are not on the Federal payroll. Why were they listed as Federal employees on Ewing's staff?

Since I exposed what Ewing was doing, he has become virtuous. He has stated, so I am told, that he intends to pay for every telephone call and every paper clip that has thus far been financed by the Federal Government for the NHA, Inc. Well, well! And how does he propose to make a post mortem count of telephone calls and paper clips used during the past 3 months? Will the present balance of $2,000 taken by NHA, Inc., from the dollars and dimes of Red Cross, Cancer, and Polio campaign receipts be sufficient to pay the salaries of Donald Kingsley, Perrott, Louis Reed, and other Federal employees numbering possibly 200 who have worked on preparing material for the assembly and who will analyze the section reports during coming weeks?

ORGANIZED LABOR WANTED A FEDERALLY SUBSIDIZED "INSURANCE" SCHEME BUT OBJECTED TO CHARITY

Most of the talking done at the discussion sessions of the medical care section of NHA, Inc., was by a small number of persons including: Mike Davis; Nelson Cruikshank, AFL; Harry Becker (until recently on staff of Children's Bureau, now with United Automobile Workers, Detroit); A. J. Asgis, professor of Public Health Dentistry at New York University; Otis Brubaker, United Steelworkers of America; Dean A. Clark, M. D., USPHS on loan to Health Insurance Plan of New York; Franz Goldmann. M. D., Harvard School of Public Health, formerly of Berlin, Germany; Sidney Greenberg, M. D., Physicians Forum; Helen Hall, Henry Street Settlement, N. Y.; Horace Hansen, general counsel, National Cooperative Health Federation; John R. Kumpel, United Rubber

Workers; and Kenneth Pohlmann, United Mine Workers of America. Pohlmann during the war was associated with Fred Mott, M. D., at the Farm Security Administration. Mott is now operating a Socialist medical care program in Saskatchewan.

The presentations in the medical care section dealt primarily with voluntary hospital and medical care plans and with national compulsory medical care insurance. One union representative after another asserted that voluntary plans were regarded only as stop-gap measures. In other words, it was apparent that organized labor would not be interested in any voluntary plan however comprehensive because there would not be as much "gravy" in it as they foolishly assumed there would be in Federal insurance. Mike Davis fought for the Marxian principle: From each according to his means; to each according to his need. Insisting that the principle of flat charges for hospital and medical care plans would do a disservice to the low-income groups, he sought sliding scale charges. He wanted a percentage of wages, as under the Wagner-Murray-Dingell bill, where workers are charged 1½ percent of wages for health insurance. The worker earning $36 a week would pay 54 cents a week for complete medical care for himself, wife, and ten children. Of course labor goes for such a proposal. Who wouldn't? The deficit would be paid from general revenues. It is a straight Communist plan for redistribution of income through a Nationwide scheme of public charity which is to bear the name of "social insurance."

BOAS ADVOCATED COMPULSION AND ABOLITION OF FEE-FOR-SERVICE

Ernst P. Boas, M. D., chairman of the lobbying group known as the Physicians Forum, presented the chief paper in favor of national compulsory medical care insurance. Through ignorance or by intent he made a number of inaccurate statements. He said that under a comprehensive Federal system "Physicians will be free to practice much as they do today." That's false, of course. He said, "It would be unfortunate if the free-for-service principle of payment were adopted as the chief method of payment." What Boas seems not to know is that even the International Labor Organization which is working for national compulsory sickness insurance has warned that the capitation method of payment, which is being proposed by advocates of compulsion, is extremely unfair to the physicians, since it calls for a promise of unlimited service to be given for a limited fee. If we are to throw out fee-for-service as administratively impossible and capitation as unfair, we are forced to accept a salaried service as the payment solution. It is unfortunate that a man as ignorant of the subject as Boas should have presented the main paper.

THERE WAS NO WORTH-WHILE DISCUSSION OF COMPULSORY INSURANCE

At no time during he discussion of compulsory insurance was there any explanation of what that type of program would mean to physicians, to patients, and to medical practice. The meeting was simply cockeyed and obviously run by a bunch of amateurs (excepting Davis) who did not know enough about the content of sickness insurance to make its implications clear to the large audience in attendance. They did not say: You understand, of course, that in asking for compulsory insurance you are asking for establishment of panel service, such as they have in Great Britain, or of salaried service, such as they have in Russia. Is that what you propose for America? I will wager there would have been less enthusiasm for Government medicine if so described. There was no discussion of costs. I was anxious to give such information but Oscar Ewing had refused to let me attend as a delegate. (I went in on a press pass which prevented my discussing any of the papers.) Labor representatives wished to know about costs, but were not told.

CRUIKSHANK OF AFL TRIED TO PULL A FAST ONE BY PROPOSING COMPULSORY SCHEME

Throughout the medical care sessions at NHA, Inc., it was apparent Cruikshank was the main needler and troublemaker. The sessions were apparently drawing to a peaceful close when Cruikshank asked to be heard. Dr. Leavell turned over the mike. Cruikshank began to present eight resolutions. They had apparently been prepared with considerable care as an instrument around which labor could rally. The old Communist technique which one sees being used all the time these days in Washington was employed by Cruikshank. That is, most of the audience had come to listen and discuss, but not to pass resolutions. The labor leaders, on the other hand, had their scheme all ready to spring at the agreed time. Cruikshank started to speak from notes. There was a commotion at the rear of the room, just as there is under similar circumstances at Senate hearings. A messenger brought in a bundle of mimeographed sheets with the Cruikshank resolutions. Peggy Stein distributed them. (See copy herewith.)

The chief recommendations were that national compulsory medical care insurance was essential and that voluntary plans should operate under the national compulsory scheme. The document was referred to the executive committee for consideration on the evening of May 3. The 14 signatories were: Nelson Cruikshank for AFL; Harry Becker for UAW (CIO); Jerry Voorhis for Cooperative League, USA; Elizabeth Christman for National Women's Trade Union League; Helen Hall for National Federation of Settlements; Mrs. Elizabeth Magee, National Consumers League; Gladys Edwards, National Farmers Union; Ernst P. Boas, M. D., for Physicians Forum; Edward L. Young, M. D., Physicians Forum; Channing Frothingham, M. D., Committee for Nation's Health; Joseph H. Louchheim, American Association for Social Workers (he is with Committee for the Nation's Health); Dr. Murray Robinson, American Veterans Committee; John R. Kumpel, United Rubber Workers; a representative of the United Mine Workers of America.

CRUIKSHANK SCHEME CAME THROUGH WRINGER IN MANGLED STATE

Cruikshank's proposals were referred to the executive committee which was loaded with lobbyists. However, the medical men thereon refused to accede to labor's demands. The Cruikshank recommendations came out of the executive committee much changed. (Copy is enclosed for study. Opinions should be expressed to Oscar Ewing at once before he reports to the President. He himself came out strongly for compulsory health insurance.)

CRUIKSHANK ATTACKED MORRIS FISHBEIN AT FINAL GENERAL MEETING OF NHA, INC., ON MAY 4

A streamlined summary of the recommendations of all sections was given by radio commentator Stanley Howe. He did a masterly job, but glossed over deep schisms. There was much unwarranted talk about "large areas of agreement." Controversial issues were soft-pedalled. All was coming to a well-engineered finale when the villain of the piece, Cruikshank, stepped forward and asked Ewing for his mike. There was quite a bit of stage play. People openly suggested the whole thing looked as though it had been rehearsed in advance by Cruikshank and Ewing. At first Ewing refused to relinquish his mike. The audience seemed pleased. The villain was routed. But no! After a little delay, Ewing called Cruikshank to the mike. Bang! He excoriated Dr. Morris Fishbein. The ill-timed blast was no credit either to him or to Ewing. The press had known about the blast an hour before it occurred.

IMMEDIATE, URGENT ATTENTION! ACT NOW!

The House Appropriations Committee made big slashes in 1949 funds for A. J. Altmeyer, Commissioner for Social Security and chief backer of I. S. Falk who has written or supervised writing of Wagner-Murray-Dingell bill. The committee cut Altmeyer's funds from $3,131,165 to $221,000 and took away most of functions. Falk's funds were cut from $229,830 to $100,000. Altmeyer is appealing to Senate Appropriations Committee at hearings on May 10. He threatens to resign. In reality, he should be fired. The Senate should not restore the cuts. Express your views at once to: Senators Byrd (Democrat of Virginia), Ferguson (Republican of Michigan), Wherry (Republican of Nebraska), Brooks (Republican of Illinois).

MARJORIE SHEARON, Ph. D.
Legislative Consultant.

Dr. SHEARON. In this appropriation bill for the Federal Security Agency called the Supplemental Federal Security Agency appropriation bill for 1949, the House subcommittee headed by Congressman Keefe made a cut of over $3,000,000 in the appropriation for Mr. Altmeyer, Commissioner for Social Security. And that, of course, is in the Federal Security Agency. They also made a cut, part of a three-million-dollar-plus cut, in the Bureau of Research and Statistics, which was cut more than in half. The statement was made that they thought that would be enough money for the functions of that Bureau.

The bill came over to the Senate Appropriations Committee, and Mr. Altmeyer endeavored to have the cut restored. Hearings were rather suddenly called May 10 and 11, and I asked to be allowed to appear.

Senator DONNELL. This was a subcommittee, was it?

Dr. SHEARON. This was a rather large subcommittee of the Senate Appropriations Committee.

Senator DONNELL. Do you know who the chairman was?

Dr. SHEARON. Yes, Senator Knowland of California. They had hearings for 3 days, and since this relates to the matter under discussion here, I should like to have my testimony—it is not very long, it is not quite 12 pages—introduced in the record at this point, and it will save my time.

Senator DONNELL. This is your testimony before the subcommittee of the Senate Committee on Appropriations, given on May 11, 1948?

Dr. SHEARON. That is right.

Senator DONNELL. It will be received and incorporated in the record in full.

(The document referred to follows:)

TESTIMONY OF MARJORIE SHEARON, PH. D., AT SENATE HEARINGS ON H. R. 6355, SUPPLEMENTAL FEDERAL SECURITY AGENCY APPROPRIATION BILL FISCAL YEAR 1949

Qualifications of Witness.—I am appearing in the public interest as a legislative consultant and an expert in Social Security. In giving my qualifications as a witness, I may state I was engaged in research in the Federal Security agency for nearly 9 years (from July 1936 to January 1945), having been 5 years in the Bureau of Research and Statistics and 4 in the Public Health Service. While with the Social Security Board, I wrote the economic brief for the defense of the Social Security Act by the then Attorney General Robert Jackson, now on the Supreme Court. I then spent 3 years as a Senate consultant, having been health consultant to the Senate Committee on Labor and Public Welfare and subsequently part-time consultant to Senator Taft. I have had occasion to study the administrative set-up in the Social Security Administration and the reports, recommendations, and legislation which have emanated from the Bureau of Research and Statistics.

Recommendations.—I shall address my testimony mainly to those sections of House Report No. 1821 which deal with the Social Security Administration. I believe the House Committee on Appropriations has been wise in recommending a cut from $3,131,165 to $221,000 for the office of the Commissioner. Insofar as the proposed savings for the Bureau of Research and Statistics are concerned, i. e., the cut from $229,830 to $100,000, I recommend serious consideration being given to cutting out the entire appropriation and abolishing this particular Bureau as unnecessary, not in the public interest, and not within the intent of the Social Security Act.

Development of Bureau of Research and Statistics in Social Security Administration.—In making these recommendations, I have in mind the law and the past and present operations of the Social Security Administration, including the Bureau of Research and Statistics. I wish particularly to bring to the attention of this committee certain pertinent facts which have been brought out during the past 3 years at other committee hearings in the House and in the Senate.

To understand the present situation in the Bureau of Research and Statistics, it will be necessary to review quickly the history of that Bureau. You will recall that as soon as this country became a member of the Socialist-dominated International Labor Organization in 1934, President Roosevelt appointed the Committee on Economic Security with a view to having social security legislation drafted in accordance with the principles which had already been laid down in Geneva. Technical staffs were appointed to assist the President's Committee. It was most unfortunate for the country that a group of nongovernmental lobbyists for socialized or Government medicine should have been chosen at that time to join the staff of experts. As a result, a report was prepared in 1935 entitled "Risks to Economic Security Arising from Ill Health." It was the work of two nongovernmental proponents for compulsory sickness insurance, the late Edgar Sydenstricker and Mr. I. S. Falk, who later became the Director of the Bureau of Research and Statistics. This report constituted the basis of the health insurance proposals included in the report of the Committee on Economic Security to the President on January 15, 1935. However, when the President made his recommendations to Congress 2 days later he did not ask for the inclusion of a compulsory health insurance program in the original Social Security Act.

On January 17, 1935, Senator Wagner introduced the economic security bill, S. 1330. Representative Doughton introduced the companion bill, H. R. 4120. This bill contained a section (402) on duties of the Social Insurance Board, which stated that the Board should have, among its other duties, the "duty of studying * * * health insurance." Now it is to be noted that President Roosevelt had had the experts draft the bill without a compulsory health insurance title, yet those same experts had included a sentence which would have made it mandatory for the Social Security Board to study health insurance. Congress rewrote that bill and a new one, H. R. 7260, was introduced on April 4, 1935, minus the mandate for the Social Security Board to have the "duty of studying * * * health insurance." The bill, amended, became law on August 14, 1935 (Social Security Act, Public 271, 74th Cong.).

Thus Congress specifically considered the question whether or not the Social Security Board was to have a mandate to study health insurance. It decided in the negative. The language of section 702 of the present law which specifies the duties of the Social Security Board does not therefore omit the study of health insurance from the mandatory duties of the Board by oversight but by express intent.

However, because Congress failed to strike out the last three words of section 702, namely, "and related subjects," which follow the listing of specific subjects which the Board is required to study, high officials in that Board, including the Director of the Bureau of Research and Statistics, have repeatedly stated that the Board was authorized to study and to make recommendations with respect to a wide range of subjects (e. g., medicine, medical care, hospital construction, compulsory sickness insurance, disability, etc.). These subjects are far removed from the cash benefits or income maintenance programs originally comprising the areas of administrative jurisdiction and mandatory research for the Social Security Board. Because of the loose wording of section 702 of the original law and the liberal interpretation thereof, the Social Security Board has engaged in a large number of research and propaganda activities that I am quite certain were not envisaged by Congress in 1935 at the time of enactment of the original law.

I, therefore, raise the question whether the Social Security Administration now has, or ever has had, the mandate to study a large variety of subjects not immediately related to the operating programs specifically covered by the present law and whether Congress ever intended it to carry on a powerful lobbying campaign for the nationalization of medicine.

When the Social Security Board was set up early in 1936, all the research functions for the various programs were included in the Bureau of Research and Statistics. At that time the public assistance program was getting under way. The programs for old-age insurance and employment security followed quickly with their own operating Bureaus in 1936. Within the Bureau of Research and Statistics, there was established in that same year a series of divisions which dealt with operating statistics and which were also concerned with studies of administration both in Washington and in the States. In those early days, there was no talk of research in compulsory health insurance.

However, on December 1, 1936, Mr. Falk entered the Social Security Board in a minor position in the Bureau of Research and Statistics. After some months, a Division of Health Studies was created in the Bureau, and Falk was made its chief at $6,400 a year on August 3, 1937. Probably no one paid much attention to the creation of that Division, for the personnel and money involved were insignificant. However, it soon became apparent that that small Division was to play a major role within the Social Security Board and was to have a profound effect on Federal legislation and on national political policies in the whole field of social legislation.

The Bureau was temporarily deflated in 1938 and 1939 when the personnel engaged on old-age insurance and employment security operating statistics were removed from that Bureau and attached to the respective operating bureaus. The last of the statistical groups to be removed from the Bureau of Research and Statistics was that of Public Assistance Statistics, which comprised a staff of 62 persons.

In 1939, when President Roosevelt's First Reorganization Plan was passed by Congress and the Federal Security Agency was set up, it was generally supposed and hoped that the Division of Health Studies would be transferred from the Social Security Board to the Public Health Service where it belonged administratively. I was told on excellent authority that Mr. Falk refused to let this change go through because he was determined to hold on to the Health Studies Section as a nucleus in the health insurance field pending enactment of legislation for compulsory sickness insurance in this country. After the several research divisions had been transferred from the Research Bureau to the operating bureaus, little remained in the Bureau of Research and Statistics in 1941 save the Division of Health Studies, a Division of Fiscal Studies, and the editorial functions.

On September 15, 1940, Mr. Falk became the Director of the Bureau of Research and Statistics at a salary of $8,000. Up to that time he had held only minor positions and had had only a small staff of around 30 persons. Overnight he became the administrative head of a staff of 186 persons. The congressional appropriation at his command jumped from approximately $80,000 to half a million dollars in 1941 ($484,955). He began to create a number of small divisions in the Bureau of Research and Statistics, which one could hardly justify, except perhaps that they served to bolster the central division in the Bureau, namely, the Division of Health Studies.

Federal lobbying activities for nationalization of medicine centered in Social Security Board.—With the larger staff and budget, Falk began to put on a more intensive campaign for the nationalization of medicine. He had been largely responsible for the drafting of the first Wagner health bill in 1939 and had endeavored at that time to induce Congress to accept the principle of compulsion. In 1943 his staff wrote the elaborate, grandiose medical title of the comprehensive Wagner-Murray-Dingell bill (S. 1161 of the Seventy-eighth Congress) which was designed to force on the entire population a Bismarckian system of Federal medicine. It would have done more than that, inasmuch as it would have given virtual control of a Federal health insurance trust fund of $10,000,000,000 annually to the Social Security Board. The bill failed to come to hearings and died in committee.

In 1944 and 1945 large sums were spent from public funds in drafting another comprehensive sickness insurance bill in the Bureau of Research and Statistics. Indeed, two bills were drafted—one S. 1050 of the Seventy-ninth Congress, which contained taxing provisions and was referred to the Finance Committee, the other S. 1606, which was referred to the Senate Labor and Education Committee.

It is now a matter of public record that the Bureau of Research and Statistics, whose activities you are this day considering, has become the nerve center of the world movement to nationalize medicine in the United States and in other countries. Without repeating the full story of the inglorious record of that Bureau, I may refer this committee to the reports of the Harness Subcommittee on Lobbying and Propaganda, particularly House Report No. 786, Eightieth Congress, first session. In this report Congressman Harness stated to the full Expenditures Committee in the House that—

"* * * the staff and resources of the Bureau of Research and Statistics in the Social Security Board were devoted freely, from time to time, to the preparation of pamphlets and propaganda literature for the CIO, the AFL, and the Physicians Forum.

"Certain documentary evidence also has come to the attention of your committee, that the Bureau of Research and Statistics in the Social Security Board also maintains close contact with movements for compulsory health insurance in other countries."

At the conclusion of that report Congressman Harness included a copy of a letter he wrote on June 30, 1947, to Hon. Tom C. Clark, Attorney General of the United States, asking that some 46 persons in the Federal Security Agency, including several of Mr. Falk's chief assistants, be investigated with a view to ascertaining whether there had been violations of section 201 of title 18 of the United States Code by employees in the departments and agencies mentioned in the report. That investigation was made by the FBI last summer and the report is now being held in the Department of Justice.

I would further call to the attention of the members of this committee to the revelations which have come out at the hearings on S. 545 and S. 1320 with respect to the activities of the Bureau of Research and Statistics. It has been brought out, inter alia, that this Bureau has been—

1. Organizing labor groups with a view to gaining their support for the Wagner-Murray-Dingell bill;
2. Issuing so-called research documents of questionable authenticity;
3. Working with, and developing policies of, the socialist-controlled International Labor Organization.
4. Sending its staff members to Europe, Japan, Canada, South America, and elsewhere for the express purpose of coordinating efforts to develop compulsory sickness insurance legislation of the Wagner-Murray-Dingell bill type throughout the world;
5. Furnishing consultative services to John L. Lewis and to other union leaders for the purpose of promoting union pension and health plans;
6. Organizing sentiment in labor unions in favor of the Wagner-Murray-Dingell bill; and
7. Cooperating with Communist-front organizations.

Resignations of professional staff.—During the period of a little more than a decade during which the Bureau of Research and Statistics has been in existence, there has been an unusually large turn-over of staff. All the members of the original senior staff who were associated with Mr. Falk in 1937 have resigned. All but one of the persons who resigned protested maladministration, waste of public funds, improper activities, and misuse of professional personnel. Several members laid the facts before Mr. Altmeyer so that he cannot now claim ignorance of the situation. I shall quote from two resignations. On March 23, 1945, Ruth E. Stocking, M. D., resigned after 7½ years in the Bureau. She wrote to Mr. Falk:

"From time to time during the past years I have tried to make clear to you my growing sense of distrust for much of the work we do. I have discussed with you my belief that the Division was not meeting its responsibility in regard to much work that needed doing.

"I already had grave misgivings as to the fruitfulness of the Division's work when Mr. Sanders was made its Chief more than 5 years ago. I so expressed myself when you discussed the possibility of his appointment. I stated then that, in my judgment, Mr. Sanders had neither the training nor the experience to fit him for the position of chief of a division of Health Studies * * *. I believed then—and I believe now—that the obligations of the Division were very important and that the director of such work required qualifications and talents which Mr. Sanders did not—and does not now—possess."

In referring to her reasons for distrusting much of the work done in the Bureau Dr. Stocking referred to a study of X-ray costs which was planned and partly executed without medical advice or referral to roentgenologists. She called attention to the fact that the study was initiated at the request of Michael M. Davis, who is the guiding spirit in the nongovernmental lobby for the nationalization of medicine, and whose organization, the Committee for the Nation's Health, is now registered as a lobbying group.

At an earlier date, on November 12, 1944, Margaret Plumley had resigned from the Bureau, stating to Mr. Falk:

"I have come to the conclusion that our ideas of what constitutes an honest study and a proper use of consultants and professional staff are too divergent for me to continue working in the Bureau. * * *"

Miss Plumley listed a number of factors which had been troubling her with regard to the Falk administration. She wrote that one such factor was Mr. Falk's responsibility for Sanders' position as Director of the Division of Health and Disability Studies and his retention of Sanders in that position "although his incompetence is clearly evident." She wrote:

"I do not need to spell out to you Mr. Sanders' inadequacies; you must be much more aware of them than I. * * * I knew nothing about Mr. Sanders when I came to the Social Security Board or I should never have accepted a position under him. I came because of my long knowledge of you, my respect for your ability and, as I believe, your integrity."

Continuing with the list of reasons for feeling troubled about the administration, she referred to—

"Disillusionment as to the character of the work done in the Division and the methods under which work is carried on. Demands for superficial jobs to be done in a hurry; work outlined as of primary importance and great urgency.

dropped without explanation after days of work under pressure and hours of overtime, picked up again for another brief flurry, and then forgotten—always a crisis but never a plan. * * *

"The trivial character of much of the work done in other sections of our Division—the blowing up of insignificant items in the progress report so that they look important. * * * I have come to have a profound distrust of the material published by the most active section in our Division. * * *

"Doubtless my departure will not change your plans and out of them will emerge not a fruitful, useful piece of work but a sterile, stuffed-shirt type of report."

Three years earlier, on September 12, 1941, shortly after I left the Social Security Board, I wrote to Arthur J. Altmeyer, then Chairman of the Social Security Board, and stated:

"For four long years I labored under the Falk regime. * * * But last spring I realized it would be impossible to be of any social value if I remained under the conditions which exist in the Bureau of Research and Statistics. I did not leave the Board until I was convinced that honest, unbiased research would, as a rule, be suppressed or vitiated under the present administrative set-up in the Bureau."

Referring to an inaccurate statement which had been prepared for Mr. Altmeyer in the Bureau of Research and Statistics and had been read into Senate hearings by him, I stated:

"Research findings used to determine agency policies and to shape social legislation should be prepared with meticulous care and with the utmost honesty. Unfortunately, the document you read into the Senate hearings was not so prepared. * * * It was devious and misleading, not by accident but by design. * * * This is not the first time that research findings coming from the Bureau of Research and Statistics have been 'fixed.' "

I have quoted from these resignations and protests because they will indicate to the members of this committee that the research activities carried on in the Bureau of Research and Statistics have been suspect for years. The senior professional staff members resigned not to seek better positions or more money, but in protest over maladministration, the issuance of untrustworthy research documents, and the appointment of professionally incompetent personnel to head the work of the several important divisions in the Bureau. Conditions have grown worse through the years. Millions of dollars have been squandered. There have been issued from that Bureau to the public, to the press, and to the Congress reports, statistics, and recommendations that cannot be trusted and that have been openly challenged at Senate hearings during the past year.

Employment of professionally incompetent and/or disloyal personnel in the Bureau of Research and Statistics.—The personnel practices within the Bureau have been nothing short of scandalous for more than a decade. The facts are known to one of the mostly highly respected of personnel men in the Federal Government—Robert Barnett. They are also well known to Mary Switzer, Administrative Assistant to Federal Security Administrator Oscar Ewing. I shall point out to this committee only one or two illustrations of the appointment of incompetent personnel. Falk elevated to the post of Chief of Medical Economics in the Bureau of Research and Statistics, a Miss Margaret Klem, who had no training in medicine or economics. She had neither a Ph. D. degree, which is considered an essential for senior research positions, nor an M. D. degree. At the time he so elevated Miss Klem over the protests of the majority of the senior staff members, he had in the Bureau a woman peculiarly fitted for the post because she had an A. B. degree in economics and an M. D. degree. I refer to Dr. Ruth E. Stocking. The trouble with her was that she was too well-informed and too honest to be acceptable to Mr. Falk. He gave the post to Miss Klem instead. At the same time he blocked the establishment of a civil service job classification for medical economist. If such a classification had been set up, Miss Klem would not have qualified for the job nor would Falk himself have been able to qualify for his own present civil service classification as a medical economist.

Miss Selma Mushkin came into the Bureau at a salary of $2,100. She was a junior professional working under a trained financial expert, the economist Dr. Eleanor Dulles. When Dr. Dulles resigned in protest over conditions in the Bureau, Miss Mushkin was groomed for the job and is now receiving something like $7,100.

When Barkev Sanders, who was originally hired to run a statistical pool, was elevated to the post of Chief of Health Studies, again the majority of the senior staff protested on the grounds of Sanders' lack of professional competence and because of his pliability in preparing statistics.

As to employment of persons disloyal to the United States, I may mention Jacob Fisher, who heads the group on interprogram benefit studies in the Bureau of Research and Statistics. He was cited by two House committees for his Un-American activities.

The point I am making is that as qualified, trained, professional personnel resigned from key positions in the Bureau of Research and Statistics and as its unsavory reputation spread, Mr. Falk elevated persons of inferior qualifications in order to hold his staff together. I recommend that the situation be investigated.

Bureau of Research and Statistics is overstaffed with high-salaried personnel.—The Bureau now has a staff of 54 persons and a budget of $229,830. The staff includes the Director, Assistant Director, and Assistant to the Director and seven chiefs of study groups. The three top salaries are $10,000, $8,778, and $8,180; the next seven ranging from $7,100 to $8,179, approximately. Thus there are 10 persons to supervise 44 analysts, statisticians, and secretaries. I submit this is absurd on the face of it and a sheer waste of public funds.

Influence of Bureau of Research and Statistics.—This Bureau, despite its small staff, has wielded an influence out of all proportion to its size. It has muddied the stream of thought in the field of medical care and social insurance and has produced an enormous amount of propaganda material designed to sell the idea that the United States should adopt a system of compulsory sickness insurance as an integral part of a system of national compulsory social insurance covering the entire population. Mr. Falk and his assistant director, Wilbur J. Cohen, have worked closely with the International Labor Organization and with the Inter-American Committee on Social Security in an attempt to put over in this country and in other countries in the Western Hemisphere systems of compulsory, government medicine. They have collaborated with two well-known lobbying groups. Mr. Falk and his assistant Cohen have been backed by Commissioner Altmeyer, whose budget you are now considering. Mr. Altemeyer himself spends a very large part of his time away from his desk in Washington. For months on end he is in Geneva. His Deputy Commissioner, William Mitchell, has just returned from Greece. You will find if you look into the activities of the Social Security Administration, that more and more of the time of key officials has been devoted to establishment, or revision of foreign systems of social insurance to conform to the Altmeyer-Falk-Cohen views of compulsion. I raise the question of whether or not this was or is the intent of Congress. Are appropriations voted for an American system of social security or to establish world systems?

The ultimate authority for many questionable activities resides in the Federal Security Administrator.—In considering what has been going on in the Social Security Administration one sees that the authority and backing for what is done in the Bureau of Research and Statistics come from Commissioner Altmeyer. He, in turn, derives his authority from the Federal Security Administrator, Oscar Ross Ewing. This committee may wish to investigate Mr. Ewing's recent activities in connection with the National Health Assembly, Inc., which he called here in Washington, May 1 to 4. It is not generally known or publicized that he established a private, fund-raising corporation under the laws of the District of Columbia for the purpose of putting over this assembly. He set up the private corporation inside the Federal Security Agency, using Government room space, telephones, and a large Federal staff. I would estimate that at least 200 persons in the FSA devoted their full time for weeks to putting over this program. It is to be noted that Mr. Ewing himself has come out for Federal compulsory medical care insurance and that he is using Federal funds and staff to promote a program wholly foreign to our American way of thinking and doing. Mr. Ewing has stated the Assembly expenses would be paid from the funds of the corporation. However, he raised only $45,000 and, as of May 4, had spent $43,000. The entire assembly was a thinly veiled propaganda scheme for promotion of President Truman's legislative program. It was financed in part by organizations which have been backing the nationalization lobby, namely, the Rosenwald Fund, the Lasker Foundation, the Milbank Fund, as well as the American Red Cross, the American Cancer Society, and the National Foundation for Infantile Paralysis.

In conclusion, it would appear that possibly much more substantial cuts might be made in the Federal Security Agency 1949 supplemental budget. The lopping off of all funds for the Bureau of Research and Statistics is recommended for your serious consideration especially since the Social Security Administration already has excessively large research staffs in the several operating bureaus for old-age and survivors insurance, public assistance, and employment security. If this committee should give favorable consideration to elimination of this particular nonoperating Bureau it would be wiping out not a research organization but a powerful Federal lobby.

Dr. SHEARON. I mention this because many things are happening in this field before different committees in the Senate and there is not too much coordination of what is going on, except on the part of nongovernmental lobbyists. The Committee for the Nation's Health is always represented at all of these hearings and they are certainly working very hard to put this scheme over.

In the hearings some time back, Senator, I was discussing the philosophy of the compulsory sickness insurance, the philosophy and implications of S. 1320, and trying to bring into the record for the benefit of the Congress and of the public, and of organized labor some of the facts.

Senator DONNELL. Might I interrupt at this point to have inserted in the record a committee print of Medical Care for the Individual: A Statement of the Issues and Conclusions; from a study by the Brookings Institution, made at the request of Senator H. Alexander Smith, printed for the use of the Committee on Labor and Public Welfare. This was issued in 1948 and bears the serial number 72298.

(The study referred to appears on p. 2441.)

Dr. SHEARON. I am referring to some of the broad implications of a medical care insurance plan for the entire country. I have referred to rules and regulations and the fact that it is planned to abolish private practice, what will be involved in the policing of such a scheme, and the fact that the freedom of choice was to be abolished. That was what we were discussing the last time I testified, and I referred in that testimony to the publication that was written by Mr. I. S. Falk entitled Medical Care Insurance, Senate committee print No. 5 of the Seventy-Ninth Congress, second session——

Senator DONNELL. 1946.

Dr. SHEARON. 1946, in which I brought out some of the statements, quoting from him, to indicate that he favors either a capitation or a salaried system, but did not favor the fee-for-service. On the following day when I was testifying, he asked to be allowed to appear, and he testified the entire morning, challenging the conclusions that I drew from his volume.

However, as you will recall, you, who had not seen this volume before, and picked it up for the first time that morning, Medical Care Insurance, as you glanced through it, your eye lit on certain passages, which you read into the testimony, and you stated that you came to the same conclusion I had come to.

Since that time I have refreshed my memory and gone through this entire issue, and I find over and over that the illustrations that are given as to administration, and the favored method pointed out again and again is the method of a capitation payment of doctors, which means that patients are included on a doctor's list. They more or less lose their individuality and become pawns that represent so much per year to the doctors on whose lists their names appear.

Senator Donnell. For the record, would you be kind enough to designate just what this document is, or I can do it. It is a document entitled "Senate Committee Print No. 5, Seventy-ninth Congress, Second Session, Medical Care Insurance—a Social Insurance program for personal health purposes," being a report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate, July 8, 1946, printed for the use of the Committee on Education and Labor, bearing serial number 86274, Washington, 1946. Thank you.

Dr. Shearon. I think it is extremely important to realize that this is in the plan, because it is not in the publicity given out, namely, that administratively, if we have an over-all so-called insurance scheme for the entire population, it would be virtually impossible to continue with the fee for service and we would have to have either a capitation system or a salaried system. That has been the experience elsewhere, and unquestionably will be the experience here, and the proponents of compulsory insurance have always stated that that was the plan that they liked best. And Dr. Boas, who gave the principal talk on compulsory insurance at the National Health Assembly, came out again for such a recommendation, that the fee-for-service method of payment would not do.

It may appear that it does not make much difference how you pay a doctor, but as a matter of fact there are far-reaching repercussions when you change from the method of paying for an individual service and decide upon, say, a capitation method or a salaried method.

Michael M. Davis, as I pointed out before, stated that the fee-for-service method was open to abuse, and, as Michael Davis stated—and I quote his words—"The use of the fee-for-service method should, therefore, be discouraged, except for specialists' services under certain conditions." He made that statement in this print of "A Nationwide health program" which was published in 1944 by the Committee on Research in Medical Economics.

Dr. Boas, the other nongovernmental lobbyist who heads the Physicians' Forum, Inc., has also stated, and I quote him, "Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained."

I do not think, however, that it is generally realized by the population at large, I do not think it is recognized by organized labor at large, that it is planned to do away with the present method of payment of doctors in this country, and to accept all of the very fundamental changes that result when you cease to pay for service at the time you get it.

Now, my next subject for discussion is "Is Panel Medicine America's choice?" That is on page 20. I question whether the American people would look with favor on a capitation or panel system of medical practice. I question whether they would like to select a family physician by going to the post office and picking a name from the list of doctors there posted. If their own doctor refused to sign up with the Government they would have to take someone else, or pay twice for their medical care, once to the physician of their choice, a second time to the Government. I think the only honest thing to do in presenting this legislation to the people is to tell them the truth about what it will mean. Explain to the mothers of this country that Congress thinks it is all foolishness for them to wish to have some particular obstetrician or pediatrician. Tell them that Congress would expect them to sign up with some general practitioner and that they could not go to a baby specialist unless the Government insurance practitioner gave his permission. Indeed, it would be well to explain to the public at large that a patient would not ordinarily be able to have the services of a specialist unless an official O. K. was given by an insurance doctor.

I might explain that that is different from the present arrangement where, even though you do go to your general practitioner and he recommends a specialist, and you rely on his advice, under an insurance system you would be going to an insurance doctor, a Government doctor, paid by the Government and regulated by the Government. He might have quite a different attitude from what he now has with respect to sending you to a specialist. He might well say "I don't think you need to go to a specialist, and I will not give my O. K." In that instance, you could not walk out of his office as you can now and say "Well, I am going anyway." You would then have to file an appeal to the Medical Supervisor, the Government Medical Supervisor in your particular district. It would be very much more difficult than at present to have the services of a specialist. Often, when you want them, you do not want to wait until the next day, the next week, or the next month to get a Government O. K. You may want to do it immediately, for yourself, or a member of your family. I do not believe these things are understood.

We have a great many more specialists in this country than in other countries. We are more prone to use their services. In New Zealand, which has a system which has been instituted of the type of the Wagner-Murray-Dingell bill, they do not have specialists' services, just general practitioners' services.

In this bill, S. 1320, we are proposing that persons could not easily go to a specialist, unless they had an O. K. from a doctor under the control of the Government, and who might be guided by other reasons than those relating to the health of the patient.

I question, further, whether the American people, if consulted, would like the idea of being herded, willy-nilly, into public clinics as is planned. I do not think they understand that. They are being told that medical practice will be the same as it is today, except that it will be better, that they will go to their own doctor, and the only difference would be that they would not have to pay for the services after they received them.

That is not the case. The system would not have the promised savings if it were not for the planned reorganization. I do not say that reorganization will produce the promised savings, but that is the plan, namely, to reorganize services, and part of the reorganization includes the treatment of more and more patients in public clinics. I do not know that people nowadays like public clinics so well that they would welcome the time when that would be their main way of getting medical care.

Ambulatory patients would be expected to go to such centers and to be cared for by salaried staff doctors who would work on 8-hour shifts. In New Zealand, which has a plan similar to the one proposed in S. 1320, people are not permitted to have their own doctors when they go to a hospital. Instead, they are turned over to salaried staff doctors because that is administratively easy. These are a few of the contemplated changes. They are fully described in the reports of the International Labor Organization and in the reports emanating from the Social Security Administration. Thus we are to move step by step from the initial condition where many doctors would refuse to sign up with the Government, to a stage 5 or 10 years hence, where more and more practitioners are expected to sign up, until finally all of them would have to come under Government control. The Social Security Administration plans are drawn for 5, 10, and 15 years hence.

Senator DONNELL. Might I interrupt you at that point? You were speaking a few minutes ago about specialists.

Dr. SHEARON. That is right.

Senator DONNELL. I would like the record at this point, for the convenience of the committee, and for the convenience of persons reading this record, or anyone else, to show that at page 10 of S. 1320, beginning at line 5, there is this language, and I will ask you if this is what you had in mind:

> Specialist, home-nursing, hospital, and auxiliary services shall be obtained from the specialist, nurse, hospital, or other person of the individual's choice, whenever the practitioner from whom he is receiving medical or dental services as benefits under this title refers him for specialist, home-nursing, hospital, or auxiliary services upon determining that such services are required in the proper care of his particular case; or whenever, upon request of the individual, an administrative medical officer, upon a like determination, refers him for such services.

Dr. SHEARON. That is exactly what I am referring to. I might say that in the rules and regulations in other countries, this is carried out in great detail. You see very clearly how restricted you are, and that you will not be getting anything like the service you have been accustomed to in this country.

Again, I do not believe the public realizes that, when they are told that health insurance is simply a different method of paying for the services, and that the services will be the same as they get now, only more and better. I refer you to the plans described in great detail in Senate Committee Print No. 5 of the Seventy-ninth Congress, second session, 1946, Medical Care Insurance, by I. S. Falk.

Both Falk and Michael M. Davis advocate group practice which is to be carried on in Government health centers. The International Labor Organization advocates the same thing, stating: "In Russia, the medical care service is based on such centers." The draft schemes and plans of the ILO "almost unanimously advocate and encourage some form of group practice" at such Government centers.

I am quoting there from a report of the International Labor Office of 1944, report IV (1) of the International Labor Congress, twenty-sixth session, the title of that report being "Social Security: Principles and Problems Arising Out of the War." That report was prepared with the assistance of our own Federal officials, and has in many respects a surprising similarity to the Wagner-Murray-Dingell bill. And there is this other thing I might mention in passing, that, insofar as I have noted in this document, the Wagner-Murray-Dingell bill of this country is the only pending legislation that is mentioned. The Taft bill is not mentioned, nor any other method of providing medical care. But, for instance, on page 75—and it is all through the document—it refers to the way the Wagner-Murray-Dingell bill of 1943 would proceed. I call such a document propaganda by Federal officials.

Senator DONNELL. What was the date of this document?

Dr. SHEARON. 1944.

Senator DONNELL. At that time, the Taft bill had not been introduced, had it, Doctor—not the present one, certainly?

Dr. SHEARON. Not the present one. As a matter of fact, the other one had not been, either, but, of course, we did have grants-in-aid bills for various parts of medical care. And no other bill is mentioned except the compulsory bill. In other words, as you read this document, you get the feeling that this is what the United States is doing. This is what is proposed—yet it was simply a piece of pending legislation.

Senator DONNELL. Pending proposed legislation.

Dr. SHEARON. Proposed legislation, and it never even got out of the committee, because that was S. 1050, referred to the Finance Committee in 1943, and they did not hold any hearings.

On pages 74 and 75, there is this section on group practice at health centers, and, well, there is this quotation:

> In certain Latin-American countries, such as Brazil, Chile, and Costa Rica, where insurance was introduced more recently, medical care * * * has been organized in the form of group practice at health centers. * * * In Russia the medical care service is based on such centers.

In other words, you are given the feeling that this is the way it should be done; because they are doing it in Chile, Brazil, and Russia, therefore, it is the best way to dispense medical care. There are other persons who do not think that way.

Thus it is evident that the Federal officials who advocate compulsory medical care insurance have not told the public the truth about what the law would do. Instead, they have smothered Congress and the public with voluminous documents that few persons can understand, full of contradictory statements. The patient is told, for instance, that when the law goes into effect he will receive a card entitling him to free medical care and hospitalization at any time from the doctor of his choice. He is told that perhaps he will not wish to choose a doctor until illness strikes. That is untrue.

Senator DONNELL. This matter I asked you about a while ago at page 10 of S. 1320, which deals with the matter of obtaining specialist, home-nursing, hospital, and auxiliary service, whenever the practitioner from whom he is receiving medical or dental services as benefits under this title refers him for specialist, home-nursing, hospital, or auxiliary services upon determining that such services are required in the proper care of his particular case, is under the heading in larger type than that in the section, reading: "How benefits obtained; free choice by patient."

Dr. SHEARON. I think that is a very misleading heading, because it is not free choice if you have a capitation system, which is the one favored by Mr. Falk in his writings, and Dr. Boas and Michael Davis. If you have a capitation system, you certainly do not have free choice. There are all kinds of limitations. There are very noticeable limitations on the freedom of choice.

If the capitation system is in effect an insured person will be compelled to select his doctor shortly after the system becomes operative, because the insurance doctors will have to have their lists of patients or they will not be paid by the Government.

A patient cannot wait until he is ill to pick his physician if they have the capitation system, because the reason for having the capitation system is to have a list of a thousand or fifteen hundred names, so the doctor can be paid so much a year for the names on that list, at whatever figures they have, perhaps $7 per head per year. So if in a given community they decide to have the capitation method, with everybody in the community entitled to medical care insurance, they have to get on some doctor's list, otherwise, the doctor would not be paid.

Senator DONNELL. It is possible, is it not, Dr. Shearon, that an individual might in the year 1948 select a particular doctor, and then, when he gets sick in 1950, find, either because of the mental or physical condition of that doctor, or rumors about his inefficiency, or perhaps because of the disease with which the patient is afflicted, that he, the patient might not want that doctor? Is that part of the point you are making?

Dr. SHEARON. That is part of the point I am making. The other side would, of course, say you must start with the general practitioner, therefore, everybody ought to have a general practitioner, and then you do what the general practitioner tells you to do.

Senator DONNELL. But he might, in 1948, select a doctor whom, when he becomes ill in 1954, he might not then want.

Dr. SHEARON. And at the time you picked the doctor, you might not be interested. Suppose you are in good health and had not gone to a doctor for 10 or 15 years. Plenty of persons do not have occasion to go to a doctor very often, but you would be compelled to pick a doctor, and you would perhaps pick one, with not such great interest as you would under the circumstances of illness. Then you would want to change. They tell you as a general principle that you can make a change easily, whereas in practice you cannot make a change easily.

Senator DONNELL. Why is that true, Doctor?

Dr. SHEARON. In Great Britain, for instance, you have to get the approval of the doctor you want to leave, and the approval of the doctor you want to go to. If you cannot get both of those approvals, you have to go to the Government and state your claim. Of course, in the meantime you might not want or be able to do it. You would not want to be annoyed if it was a member of your family. It sounds good in theory, but it does not work out ordinarily from the administrative viewpoint. With doctors having 1,000 or 1,500 names on their lists, you could not have people moving in and out every day. It would be very confusing. So it is generally specified that they shall not change doctors until the end of a quarter.

Senator DONNELL. In this section 203, page 9 of the bill, there is this language:

> Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection: *Provided*, That the practitioner, medical group, hospital or other person has agreed under part B to furnish the class of services required and consents to furnish such services to the individual.

What do you think is the meaning or effect of that sentence?

Dr. SHEARON. There again, you have administrative difficulty, especially during the early years, and perhaps for a long time you would have a good many recalcitrant physicians, and recalcitrant patients.

Senator DONNELL. If you happened to have a doctor you selected in 1948, and you got sick in 1950 and needed a doctor in 15 minutes, you would not have much time to go to the office and make a change, would you?

Dr. SHEARON. That is correct.

Senator DONNELL. And there might be very great and dangerous situations that would develop there in the very process of attempting to change; that is true, is it not?

Dr. SHEARON. That is perfectly true, and that is not generally realized, because this is very involved, and most people do not think of administrative difficulties. It has been thought of by the people in the Government who are working on these administrative proposals, who have studied them very carefully.

As I pointed out before, the administration in other countries has been written up in great detail, and the rules have been published, so we know about how such a system works in other countries. And they do not have the problems we would have in a country as large and diverse as ours. It just complicates a great many things for the patient and his physician, and causes a great deal of red tape, getting the OK for this and that. And, of course, in the early years there would be many doctors who would not come into the scheme at all. The taxes, however, would go into effect immediately, and then everyone would be taxed. The Government would be in the position of promising these services, as in New Zealand where for 2 years they could not deliver the services. They collected the tax, and the medical profession refused to go into the servitude planned by the central government. The same thing might happen here, and might exist for a long time, where you would be paying a tax for these so-called free benefits, and you would not get them, because the doctors here would not sign up. Then you would be compelled to take any available insurance doctor. And I will venture to say that the doctors who would go in for this sort of thing would be, shall we say, the men of less skill, who had not been able to make very much in a professional practice, and who would, therefore, welcome the security of Government pay, and men who ideologically believed in state socialism, and would go in for ideological reasons. You would find many doctors who would not go in, because they would know they could not give good care under such an arrangement.

That is not the intention of the bill. I am not in any way implying that Senator Wagner or Senator Murray or any Senators who put their names on this bill thought otherwise than that this was good legislation, and would produce improvement in the distribution of medical care. But the people who wrote the legislation knew quite differently. That is, the people in the Federal agency. These are very serious matters, because you are dealing with life and death. It is bad enough when you have a bad law in any field, but here, when you are dealing with life and death, it is a very serious matter, and deserves the most careful consideration.

And yet, we in this country are moving along at a very fast pace. We had the National Health Assembly, with delegates from all over, coming in and saying this was a wonderful idea, and we ought to have compulsory insurance. They do not know what they are asking for. That is why I am going to great lengths and taking a great deal of time and trouble to bring these facts out in the open, where they can be viewed by all who wish to learn about the subject.

Senator DONNELL. This assembly, conducted in Washington, about which you testified, even though it was selected in the manner to which you referred, did not recommend compulsory medical-care insurance, did it?

Dr. SHEARON. Mr. Cruikshank individually at the last minute in the medical care section did have such a resolution passed.

Senator DONNELL. Of the A. F. of L.?

Dr. SHEARON. Yes. He had a very important part in running the show behind the scenes at this national health assembly.

Senator DONNELL. Did the assembly pass that resolution?

Dr. SHEARON. No, but they passed a resolution of goals, and, so far as Mr. Cruikshank and organized labor were concerned, they think they have won quite a victory, and the wording is such that it could mean governmental compulsory insurance to the labor people, and to the medical people it would not mean that.

Senator DONNELL. Do you have that wording there?

Dr. SHEARON. Yes, I have.

Senator DONNELL. Will you read that into the record?

Dr. SHEARON. I can give you the statement introduced by Mr. Cruikshank, and as it came out of the committee. Mr. Cruikshank said afterward he had in mind compulsory insurance. Here is the wording as Mr. Cruikshank introduced it. This was done very late in the session, in the afternoon of the last medical care session. He covered eight points for immediate goals.

One of them was a national health insurance plan, assuring free choice of doctors, professional freedom for the doctors, and decentralized administration through wise utilization of State and local bodies in order to bring about the benefits of health insurance to all who need it. That is a national health insurance plan. Then a statement in regard to voluntary insurance. Voluntary insurance plans which provide services and which meet acceptable standards should continue under a national health insurance plan.

Well, of course, that is all foolishness, because if you have a national compulsory plan, the voluntary plans will pass out of the picture before very long. People cannot afford to pay the heavy taxes involved in a national compulsory scheme and at the same time go out and buy voluntary insurance. They would just pass out, and Mr. Altmeyer has admitted that at the hearings.

Senator DONNELL. That is what Mr. Cruikshank proposed?

Dr. SHEARON. That is what he proposed.

Senator DONNELL. How did it come out?

Dr. SHEARON. It came out—should I say with weasel words? That is what they were. "The principle of contributory health insurance should be the basic method of medical care for the large majority of the American people."

The "principle of compulsory health insurance" has been used for years by the lobbyists for national compulsion, as the method of describing the Wagner-Murray-Dingell bills.

Senator DONNELL. I am wondering if you said what you meant there. What has been used for years?

Dr. SHEARON. The words, "the principle of contributory health insurance."

Senator DONNELL. You said the principle of compulsory health insurance.

Dr. SHEARON. I thought I said contributory health insurance.

Senator DONNELL. Will you start over, and let us get the record clear? What was adopted?

Dr. SHEARON. This was adopted.

(The material referred to by Dr. Shearon was submitted as follows:)

National Health Assembly, Inc.	Section 8, Medical Care May 3, 1948

STATEMENT OF IMMEDIATE GOALS FOR NATIONAL HEALTH SECURITY

Introduced by NELSON CRUIKSHANK, AFL.

(Copy of Mimeographed Sheet Distributed by Margaret Stein, of the Committee for the Nation's Health)

1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical and mental health should be available to all without regard to race, color, creed, residence, or economic status.

2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services, and avoid the indignities of a means test.

3. Health insurance should be accompanied by such use of tax funds as may be required to:

   (*a*) Furnish services which are public responsibilities;

   (*b*) Supplement health insurance as necessary to provide adequate services for the whole population.

4. Voluntary prepayment group health plans organized on a community or industrial level, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means. It is recognized, however, that even under the most favorable circumstances such voluntary plans cannot be expected to cover the health needs of the entire nation.

5. The people have the right to establish voluntary insurance plans on a cooperative or industrial basis and legal restrictions upon such right, now existing in a number of states, should be removed.

6. High standards of service, efficient administration, and reasonable costs require:

   (*a*) Coordination of the services of physicians, hospitals, and other health agencies in all phases of prevention, diagnosis, and treatment;

   (*b*) Efficient cooperation between the providers and the consumers of such services under the general principle that the responsibility for general policies, finances, and administration should rest preponderantly upon the lay group; for professional standards and procedures, upon the professional group; for mutual consultation on all matters of joint interest, upon both groups.

7. A national health insurance plan, assuring free choice of doctor, professional freedom for the doctor, and decentralized administration through the maximum utilization of state and local bodies is necessary in order to bring the benefits of health insurance to all who need it.

8. Voluntary insurance plans which provide services and which meet acceptable standards should continue under a national health insurance plan.

Delegate	*Organization*	*Delegate*	*Organization*

Distributed by The Shearon Medical Legislative Service, 610 Columbian Building, Washington, D. C.

Copy of Revised Cruikshank Recommendations

National Health Assembly, May 1–4, 1948, Hotel Statler, Washington, D. C.

CONCLUSIONS OF THE PLANNING COMMITTEE, SECTION 8, MEDICAL CARE

After conclusion today (May 3) of discussion in the Medical Care Section, the Planning Committee of the section unanimously reached the following conclusions, preliminary to preparation of its final report:

1. Adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical, mental, and social health should be available to all without regard to race, color, creed, residence, or economic status.

2. The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services, and avoid the indignities of a "means test."

3. Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional
   (*a*) services to persons or groups for whom special public responsibility is acknowledged and
   (*b*) services not available under prepayment or insurance.

4. Voluntary prepayment group-health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care, particularly in rural areas. Hence such plans should be encouraged by every means.

5. High standards of service, efficient administration, and reasonable costs require:
   (*a*) Coordination of the services of physicians, hospitals, and other health agencies in all phases of prevention, diagnosis, and treatment;
   (*b*) Effective cooperation between the providers and the consumers of such services.

6. The people have the right to establish voluntary insurance plans on a cooperative basis and legal restrictions upon such right (other than those necessary to assure proper standards and qualifications), now existing in a number of States, should be removed.

7. A medical-care program by itself will not solve the health problems of the Nation. It must be coordinated with all efforts directed toward providing the people with adequate housing, a living wage, continuous productive and creative employment under safe working conditions, satisfying recreation, and such other measures as will correct conditions that adversely affect the physical, mental, and social health of the people.

8. There are areas on which the Planning Committee is not yet prepared to report. In the meetings of the Medical Care Section, differing views were expressed as to the method of effectuating the principles of prepayment or insurance. Some believe it can be achieved through voluntary plans. Others believe that a national health insurance plan is necessary.

The Planning Committee, Medical Care Section

Dr. Hugh Leavell, Professor of Public Health Practice, Harvard School of Public Health, Boston, Mass., Chairman.

Dr. Ernst P. Boas, 1185 Park Avenue, New York City, Chairman, The Physicians Forum.

Mr. Nelson Cruikshank, Director, Social Insurance Activities, American Federation of Labor, Washington, D. C.

Mr. Horace R. Hansen, General Counsel, National Cooperative Health Federation, 1631 Marshall Avenue, St. Paul 4, Minn.
Dr. Thomas A. McGoldrick, 294 Clinton Avenue, Brooklyn, N. Y., Member, Council on Medical Service, American Medical Association.
Dr. James R. McVay, 406 West Thirty-fourth Street, Kansas City, Mo., Chairman, Council on Medical Service, American Medical Association.
Mr. Harry Read, Executive Assistant to the Secretary-Treasurer, Congress of Industrial Organizations, 718 Jackson Place NW., Washington, D. C.
Dr. C. Rufus Rorem, Executive Secretary, Philadelphia Hospital Council, 311 South Juniper Street, Philadelphia, Pa.
Dr. Louis Wright, Chief of Surgery, Harlem Hospital, One Hundred and Thirty-sixth and Lenox Avenue, New York 30, N. Y.

Distributed by The Shearon Medical Legislative Service, 610 Columbian Building, Washington 1, D. C.

Senator Donnell. Was that by the section, or the entire assembly?

Dr. Shearon. No. It was adopted by a steering committee, which was picked, shall we say, to steer the right way.

Senator Donnell. Who were on that steering committee?

Dr. Shearon. Dr. Hugh Leavell, professor of public health practice at Harvard; Dr. Ernst P. Boas, Mr. Nelson Cruikshank, Mr. Horace R. Hansen, Dr. Thomas A. McGoldrick, Dr. James R. McVay; the next name is Mr. Harry Read, but he was not present, and his place was taken by Harry J. Becker, who for a long time was with the Federal Security Agency, an active proponent of the Wagner-Murray-Dingell bill, and who is now with the United Automobile Workers; Dr. C. Rufus Rorem, Ph. D., and Dr. Louis Wright, M. D.

Senator Donnell. Who selected that committee?

Dr. Shearon. I am not qualified to answer that question.

Senator Donnell. Who is Dr. Leavell?

Dr. Shearon. He is professor of public health practice at Harvard, Harvard School of Public Health. He was the chairman.

Senator Donnell. He was chairman of this steering committee?

Dr. Shearon. Chairman of the medical care section, and on the steering committee.

Senator Donnell. Dr. Boas has been frequently mentioned in the testimony?

Dr. Shearon. Yes.

Senator Donnell. Mr. Cruikshank is a representative of the American Federation of Labor. Is he a doctor?

Dr. Shearon. No. He is director of their social insurance activities, and proponent of the Wagner-Murray-Dingell bill.

Senator Donnell. Is Mr. Leavell a proponent of the Wagner-Murray-Dingell bill?

Dr. Shearon. No. As a matter of fact, most of his function was presiding, and he did a very fair and equitable job. He has not been in this field. I do not believe he knows too much about it.

(Pursuant to the interrogatory Dr. Shearon subsequently submitted the following:)

NATIONAL HEALTH ASSEMBLY—GREATEST NONPOLITICAL NONLOBBYING, CHARITABLE MEETING OF ITS KIND EVER HELD IN WASHINGTON—MEDICAL CARE SECTION RUN BY SAME ORGANIZED MINORITY THAT RIGGED APHA PLATFORM IN 1944

Do you remember how Falk, Perrott, Mountin, Sinai, and their associates worked during 1944 to rig the platform of the American Public Health Association? The subcommittee on medical care of the committee on administrative practice of the APHA held its third meeting at the Hotel New Yorker in New York on June 1 to 2, 1944. Louis S. Reed from Perrott's staff in USPHS was a guest and served as secretary. The following 12 persons (with affiliations at that time as indicated) were present: Dr. Joseph W. Mountin, chairman, USPHS; Dr. J. Roy Hege, North Carolina health officer; Dr. Earle G. Brown, New York health officer; Dr. Hugh R. Leavell, then Louisville health commissioner, now Harvard School Public Health; Dr. David D. Carr, Kansas health officer; Dr. Edwin F. Daily, United States Children's Bureau; Mr. George St. J. Perrott, USPHS; Mr. Graham Davis, Kellogg Foundation; Miss Marion G. Randall, VNS, New York; Mr. I. S. Falk, Social Security Board; Dr. Edward S. Rogers, assistant health commissioner, New York; Mr. Nathan Sinai, University of Michigan.

That subcommittee considered the draft report on a national health plan, presented by Nathan Sinai on behalf of Daily, Falk, Reed, Rogers, and Sinai. It also planned the rigging of the APHA platform in favor of national compulsory health insurance.

But NHA, Inc., was to be something different. It was to be simon pure and lily white. Oscar Ewing said so. Indeed, it has been so described in some quarters. Yet lo and behold, Dr. Hugh R. Leavell, who was in on the 1944 deal, was made chairman of the medical care section of NHA, Inc. Louis Reed, who did the leg work in 1944, served as secretary and general assistant to Dr. Leavell before and during meetings. Louis picked the section 8 delegates. Howard M. Kline, a former Perrott man now paid by APHA, was executive secretary of NHA, Inc. The Levys, Laskers, and Rosenwalds, who back Mike Davis, aided in financing NHA, Inc., as did Red Cross and Cancer Society.

A small organized minority forced through the 1944 platform of APHA in a wholly undemocratic fashion. (See Journal of American Medical Association, vol. 126, no. 7, p. 434, Oct. 14, 1944, and article by Dr. W. G. Smillie in American Journal Public Health, June 1945.) A similar small organized minority, including some of the same persons who were operating in 1944, was at work in the medical care section of NHA, Inc. They tried the same surprise tactics and accomplished part of their purpose. The persons running this show were: Mike Davis, Boas, Dean Clark, Nelson Cruikshank, Peggy Stein. Silent partners were Louis Reed, Perrott, Falk, et al.

People who have worried about the sources of funds for NHA, Inc., may recall that Warren F. Draper, M. D., Deputy Surgeon General Retired, USPHS, is now assistant to the vice president, health services, American National Red Cross. Did Draper have anything to do with gaining a contribution from the Red Cross for the charitable NHA., Inc.? Those of you who sought delegates' passes to the assembly and were turned down may find consolation in the fact that the Red Cross had 12 delegates. Perhaps if you could have laid hands on some charitable funds and could have made a contribution, you too might have purchased a place among the delegates to NHA, Inc.

Ewing was so punctilious about those charitable funds. No Government money would be spent. Not a stamp, not a paper clip would be purchased with Federal funds. Ho-hum! Now that the shouting has died and the political publicity has been obtained, the story is different. NHA, Inc., publicity is being mailed out in penalty envelopes of the PHS and FSA. Mrs. Loretta April, of Perrott's staff, who served with Senator Pepper so long on the Wartime Health Subcommittee of the Committee on Education and Labor, is now in charge of NHA, Inc., publicity. Charity, sweet charity!

(The Shearon Medical Legislative Service, 610 Columbian Building, Washington 1, D. C., June 11, 1944.)

Senator DONNELL. Who is Mr. Hansen?

Dr. SHEARON. Mr. Hansen is the general counsel of the National Cooperative Health Federation.

Senator DONNELL. What is that organization?

Dr. SHEARON. It is a national organization that includes in its membership cooperative health federations.

Senator Donnell. Does it favor such legislation as the Wagner-Murray-Dingell bill, if you know?

Dr. Shearon. I think that would be largely their stand.

Senator Donnell. Who is Dr. McGoldrick.

Dr. Shearon. He is a member of the council on medical service of the American Medical Association.

Senator Donnell. Council on medical service of the A. M. A.?

Dr. Shearon. He is a representative of the A. M. A.

Senator Donnell. Dr. McVay comes from Kansas City, and is very strongly opposed to the Wagner-Murray-Dingell bill.

Dr. Shearon. That is correct. He is from Kansas City.

Senator Donnell. Mr. Becker, you told us, was formerly with the Federal Security Agency.

Dr. Shearon. And has been very active in this medical care section. He was formerly with the Federal Security Agency, and is now with the United Mine Workers.

Senator Donnell. C. Rufus Rorem, who is he?

Dr. Shearon. He has been associated with Mr. Falk for many years. He was with him on the Committee on the Costs of Medical Care.

Senator Donnell. Mr. Isidore Falk?

Dr. Shearon. Yes.

Senator Donnell. Dr. Rorem has been?

Dr. Shearon. I want to make that plain. He was associated with him on the Committee on the Costs of Medical Care, back in the late twenties and early thirties. He is a hospital expert in the accounting field. Some persons, at least, have been in doubt as to what his stand in this whole matter is, whether he is for or against compulsion, and he has not always made it too plain.

Senator Donnell. Who is Dr. Louis Wright?

Dr. Shearon. He is from a hospital in Harlem. It appeared he was there more as a representative of the minority, of Negroes, and also because of his connection in the Physicians' Forum.

Senator Donnell. Now, that group's recommendation to the Medical Care Section, is what you are about to read, is that right?

Dr. Shearon. Yes. I gave you the statement by Nelson Cruikshank, in which he tried to have them put through these goals for compulsory contributory health insurance, and with the voluntary plans coming in under the national health insurance plan.

Then, as the thing finally came through, there were eight recommendations. It might be just as well to have these put into the record.

Senator Donnell. They will be included in the record.

Dr. Shearon. He makes the statement:

> The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the unpredictable sickness costs, abolish the economic barrier to adequate medical services, and avoid the indignities of a means test.

Then he goes on to state:

> Health insurance should be accompanied by such use of tax resources as may be necessary to provide additional services to persons or groups for whom special public responsibility is acknowledged, and services not available under the prepayment or insurance.

The thing you are left in doubt about here is, it does not actually put the word "compulsory" into the statement, so that theoretically it might be done either by a Federal compulsory scheme, or by a voluntary scheme, but the voluntary schemes were damned right along as being inadequate, and as not providing this over-all needed care. So they talk about providing services for the entire population. I believe everybody knows that voluntary plans will not do that. So, by interpretation and indirection, you come to the conclusion that what they came out with was a recommendation for a compulsory scheme, if you are going to cover the entire population.

Senator DONNELL. Was that decision unanimous?

Dr. SHEARON. I do not know. It came out from the section. It was very hurriedly done. It was proposed in the late afternoon, and this recommendation came through during the evening, and was brought out in the morning. This will be published, and given out as the recommendations made at this National Health Assembly.

Senator DONNELL. Was this document you have just read from, the way in which it came out of the committee, adopted not only by the section on medical care, but also by the assembly itself?

Dr. SHEARON. No. As a matter of fact, it was said in advance that there were not going to be resolutions and that sort of thing, that they just came together to discuss these matters. Of course, everybody tried to put through resolutions.

Senator DONNELL. Was this adopted by anybody except this group?

Dr. SHEARON. It came out as conclusions of the Planning Committee. Here is the Planning Committee.

Senator DONNELL. Is that the conclusions of the Planning Committee that you just read?

Dr. SHEARON. "Conclusions of Planning Committee, Section 8, Medical Care." It was not even referred back to the delegates who were there.

Senator DONNELL. Nothing was referred back to the entire assembly?

Dr. SHEARON. It was not referred back even to the entire Medical Care Section. It was done by this small group, and, judging from the composition of the small group, I should say that the physicians on it were intimidated with a gun at their heads, considering the whole proposal, and considering what came out.

Senator DONNELL. You do not know if Dr. McVay approved this?

Dr. SHEARON. I do not know anything about it, because I was not in on it.

Senator DONNELL. I know that Dr. McVay has been very strongly opposed to the Wagner-Murray-Dingell bill. He has told me so, and has conferred with me on at least one occasion in Kansas City.

Dr. SHEARON. So was Dr. McGoldrick. When the statement goes into print, many people will misunderstand it, and there will be an assumption that organized medicine has come along with this principle.

Senator DONNELL. It says:

> After conclusion today (May 3) of discussion in the Medical Care Section, the Planning Committee of the Section unanimously reached the following conclusions preliminary to preparation of its final report.

Was there a final report made later by the Planning Committee of the Section, do you know?

Dr. SHEARON. I did not find any other report, but it is possible a final report will be turned in to Mr. Ewing. There was nothing put out at the time, at the end of the meeting. Of course, this was done, as you see, after the last session of the Medical Care Section.

Senator DONNELL. At the top of this page I am reading, it says "National Health Assembly, May 1 to 4, 1948." Did the National Health Assembly itself convene again on May 4?

Dr. SHEARON. That was the final day, at which there were simply summaries of some of the main proposals, and some of those who made reports from other sections did not say much. It was just a few of the highlights.

Senator DONNELL. These "conclusions unanimously reached by this Planning Committee preliminary to preparation of final report," were not acted upon by the Assembly on May 4?

Dr. SHEARON. No.

Senator DONNELL. Nor by the assembly on May 3 after the formulation of those conclusions, is that right?

Dr. SHEARON. There was no action taken. That is correct.

Senator DONNELL. There was no action taken by the assembly?

Dr. SHEARON. Not by the assembly, nor by the delegates who met to discuss these matters.

Senator DONNELL. Well, are the conclusions of this National Health Assembly given out publicly, and can anybody go and see them?

Dr. SHEARON. Yes; they were given out publicly.

Senator DONNELL. Not just this document?

Dr. SHEARON. Oh, yes, they had a press release.

Senator DONNELL. Can you go to Mr. Ewing's office and see it?

Dr. SHEARON. I have three volumes, and I would not have them if they were not given out publicly. They had a room in which they gave out thousands of copies.

Senator DONNELL. I was wondering if this final report was ever prepared.

Dr. SHEARON. I do not know. I could find out.

(Subsequently Dr. Shearon advised that there was no other report from the Medical Care Section of the National Health Assembly, but that on September 2, 1948, the President issued a report of the Federal Security Administrator and recommended adoption of national compulsory medical care insurance.)

Senator DONNELL. Would you mind finding out?

Dr. SHEARON. I will be glad to do that.

Senator DONNELL. And at our next session, or as soon as you can do so, will you furnish it to us?

Dr. SHEARON. Yes. I think that is important.

Senator DONNELL. Doctor, it is 10 minutes to 1. I think it is advisable to recess. We are sorry to have taken so much time this morning, although the matter presented was important, and although it related to another bill, it was necessary that it come before our subcommittee. The committee will be in recess until 10 o'clock tomorrow morning. Can you be here then?

Dr. SHEARON. Yes; I can.

Senator DONNELL. The copy of the revised recommendations of the Medical Care Section of the National Health Assembly has been included in the record. At this point there will be included the committee print entitled "Medical Care for the Individual, Made at the Request of Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, Printed for the use of the Committee on Labor and Public Welfare."

(The committee print referred to is as follows:)

MEDICAL CARE FOR THE INDIVIDUAL

A Statement of the Issues and Conclusions From a Study by the Brookings Institution Made at the Request of Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare

NOTE.—This Print contains only the extracts of a statement of the major issues and conclusions of the subject report. The full context of the report will be published by the Brookings Institution at a later date.

I. The Issues With Respect to Medical Care for Individuals

The traditional position of the United States in regard to medical care has been that it should not be withheld from an individual requiring it on the ground that he lacked the resources to pay the costs. The existing arrangements for providing free service or services at less than cost are an evolutionary composite of devices not sufficiently planned or properly integrated to be called a system. Going far back in American history one finds such devices as:

The physician who attended the poor without compensation.

The local poor authorities who hired a physician to attend the poor or who paid the doctors in the locality fees for attending them.

Voluntary hospitals established and at least partially maintained by private philanthropy that made provision for the care of the poor without charge or at far less than cost.

Public poor authorities or private philanthropic agencies that supplied the funds to permit needy persons to be hospitalized and to receive service in institutions that required payment.

Public hospitals, supported in whole or in part by local taxation, giving services free or at much less than cost.

Free clinics publicly or privately supported.

Publicly supported institutions for the care of special classes of sick people, notably the mentally ill and the tubercular.

All these are expressions of the free initiative of the American people to relieve suffering and of a desire to serve or to be usefully occupied. It is, furthermore, an acknowledged fact that health is something that can be achieved through cooperative effort.

The issue before the Congress is not therefore whether it shall be the policy to make medical care available to those who cannot afford to pay its full cost, but how the activities in this field shall be planned, integrated, and systematized.

TWO MAJOR PROPOSALS

Two major plans are under consideration by the National Government:

The first, which may be called one of growth and experimentation, is for the National Government to make grants-in-aid to the several States to enable each State in its own way to develop a program for providing the essentials of sound medical care for the indigent or for the medically indigent.[1] As is the case in many other grant-in-aid programs, the national grants would be conditional and would be given only to those States whose programs complied with the requirements set up by the National Government. The expectation is that many of the States would develop their own systems by integrating existing medical services and filling in any gaps. Under this plan individuals and families who are neither indigent nor medically indigent would presumably make their own provisions for medical care. It is expected, however that the rapid growth of voluntary hospital insurance and the development of health insurance plans and prepayment plans will continue. It is entirely possible that under the grant-in-aid law some States would develop State medical insurance plans for selected classes or even for the entire population.

---

[1] The medically indigent are individuals who are normally self-supporting, but cannot meet additional costs resulting from needs for medical care.

The second plan, which may be called revolutionary, is to adopt a system of compulsory health insurance under which "every employed and self-employed person" would be taxed to support a health fund. From this fund would be paid the costs of medical care for those persons who elect to receive it from such practitioners as agree to conduct their practice in accordance with the laws and regulations governing insurance practice. Conceivably some practitioners would decline to affiliate with the system. Persons who so chose would be free to go to them, but they would do so at their own expense. Insured persons would, insofar as practicable, have free choice of general practitioners affiliated with the system. Practitioners would be paid in any one of three ways or a combination of them: (1) Fee-for-service—the present common way; (2) per capita; or (3) salary for full or part time. Presumably the practitioners of each class in an area would have a voice in determining the method of payment to be used in that area. The National Government would have general supervision over the entire system, but under the most recent proposal of this type administration would be decentralized.

Some persons may be opposed to either of these two major plans and take the position that the National Government should not take action in the field of individual medical care. It is not the purpose of the present study to consider that issue specifically, but much of the evidence considered in it wil be of interest to persons who take that position. Major attention will be devoted to the issues that are involved in a choice between the two major proposals.

HEALTH OF THE AMERICAN PEOPLE

A very substantial body of citizens when confronted with a proposal for far-reaching changes, especially when such changes may affect their customary way of life, will want to know first whether the changes are necessary, or at least desirable and advantageous. They may very properly ask, "How bad are health conditions in the United States?"

This broad question has to be broken down into subquestions partly on the basis of what reasonably accurate factual data are available to answer the questions objectively.

International comparisons

How does the United States compare with other countries with respect to mortality? On the average, how does the expectation of life in the United States compare with the expectation in other countries? It would obviously be misleading to compare conditions in the United States today with those now prevailing in countries devastated by the war, and hence comparisons will be made on the basis of prewar figures.

More specific questions may be asked: How does the United States compare with other countries with respect to infant mortality, maternal mortality, and tuberculosis?

The United States has a substantial nonwhite population, whereas certain of the other countries have either an almost exclusively white population or base their mortality statistics on their white population. Since for various reasons, which will be considered in later chapters, the mortality of the nonwhites is almost everywhere higher than that of the whites, the international comparisons will at times be between the white populations.

Interstate comparisons

When the questions with respect to how the United States compares with the leading foreign countries on the basis of mortality statistics have been considered, the next ones will deal with how the several States and geographic areas compare with each other in respect to mortality. Because of the wide variation among the States in the proportion of nonwhites, many of the comparisons will be based first on white populations and then others will be based on Negro or nonwhite populations. Again, to make the data more specific, infant mortality, maternal mortality, and certain other major causes of death will be considered.

Naturally, in the course of the examination of the mortality data for States, questions will arise as to how the great urban centers compare with smaller cities and rural areas. Although in some instances the available data are of limited dependability, they will be presented.

In some cases the rank of the States with respect to mortality will be compared with their rank in per capita income, in an attempt to see what extent income affects mortality.

The significance of the draft data

The data with respect to the health and physical and mental condition of the men of military age, obtained through the operations of the Selective Service Act, have been widely used in the discussions of provisions for individual medical care. They were not collected for the purpose of disclosing either the extent of or the unfilled need for such care, but were a byproduct of the administrative act of drafting men who met the physical and mental standards for military service as established by the armed forces. The first question which must be asked is, what importance can be attached to them as evidence of the health index of the Nation, and how far do they throw light on the extent of individual medical care in the United States and the unmet need for such care? Another related question is, what, if any, evidence significant to the present issue can be derived from them?

ILLNESS AND MEDICAL CARE STATISTICS

The use of mortality data for international and interstate comparisons was dictated by the fact that data with respect to illness and other conditions requiring individual medical care are not currently and systematically collected in the United States. For factual material on illness and medical care, resort must be had mainly to sporadic special studies that speak as of a specific year. Because of the short time available for this study, main consideration will be confined to the study by the Committee on the Costs of Medical Care and to the health survey directed by the Public Health Service as a Work Projects Administration project. What significant facts emerged from these studies? To determine the significance of the facts, some consideration will have to be given to the question, what were the limitations resulting from the methods employed in these surveys? It may be said here that methods will be considered only insofar as they have a bearing on the results.

ABILITY TO PAY FOR MEDICAL CARE

The report of the Committee on the Costs of Medical Care contained data on what the families paid for medical care. To a limited extent consideration of that report introduces the second major issue: To what extent can American families afford to pay the costs of medical care? What a family can afford for medical care is not exclusively a question of what the costs are, but also of income and the uses made of that income. To give background for consideration of the question, it seems necessary to present and discuss briefly income and consumer expenditure statistics. These data should throw light on the question:

> To what extent does lack of adequate medical care result from inadequate income and to what extent does it reflect failure or unwillingness to give medical care a high priority in use of available funds?

COMPELLING INSURANCE AND POOLING RISKS

With a broad background of data with respect to health conditions in the United States, the extent to which medical care is provided, and the capacity of the people to pay, the question can be approached:

> With respect to those who have the capacity to pay for adequate medical care, is it desirable to compel insurance and pool the risks?

The introduction of this question largely marks the end of intensive, detailed, factual presentations and entrance into the realm of judgment, of opinion, and of economic, social, and governmental philosophy. In it one sometimes encounters an almost complete agreement with respect to the facts but diametrically opposite conclusions as to the course which should be pursued in the light of those facts.

The detailed questions which require consideration under this extremely broad one are:

> Would compulsory insurance give broader coverage than a system of leaving individuals with capacity to pay free to procure medical care in their own ways or free to procure it in the way prescribed by the State in which they dwell?
>
> Would compulsory insurance reduce the costs of medical care for persons who have the means to pay for it if they elect so to use their resources?
>
> Could persons who have the means and the desire regularize and stabilize the costs of medical care through prepayment plans, voluntary insurance, and other similar devices? What have been the developments in the voluntary field and what are the prospects for further development?

> To what extent are the needs for medical care of individuals within their control or control of members of their family? How much of a factor is hygienic living?
>
> What importance is to be attached to education, welfare service, and other devices to further hygienic living?

EFFECTS OF SYSTEMS ON PRACTITIONERS

The questions just listed view the problem from the standpoint of the consumer of medical service. Since the quality of medical care is largely dependent on the practitioners, another major question is:

> What would be the effect of the two systems on the economic situation of the practitioners engaged in medical care?

A common allegation is that many poor rural areas do not offer sufficient economic reward to attract competent practitioners. The facts here require careful examination since the advent of the automobile and good roads have deprived local political boundaries of their old significance and have substituted nonpolitical normal-trade areas as the real units. If it be assumed, however, that there are areas which do not offer economic inducements to practitioners, could the situation be met as well by a State plan with a Federal grant-in-aid as by a compulsory health-insurance system?

An economic difficulty encountered under the old system of medical care was that practitioners were called upon to render much free service, and often they could not collect their fees for services which were not intended to be free. Let it be assumed that it is decided as a matter of policy that practitioners are to be relieved of this economic burden and are to carry no more of the burdens of care for the needy than do other citizens of like capacity to pay. Could voluntary insurance devices and payments under State plans meet the situation as well as compulsory insurance?

Under a compulsory health insurance plan the fees or emoluments of practitioners would have to be fixed by the Government. The Government would be under pressure from consumers or taxpayers to hold down the rate of compensation and from the practitioners, presumably highly organized, to advance the rate. Is it possible to predict the effect of fee fixing by government on the economic status of practitioners?

Under present practices some physicians—notably specialists—have adjusted their fees to the capacity of patients to pay. Low fees or no fees for the poor have perhaps justified high fees for the well-to-do. The well-to-do, moreover, frequently have sought the services of the practitioner whose reputation and skill are such that despite high fees he has a large practice. If the population is well covered by compulsory insurance and fees are fixed for specific services, will high reputation and outstanding skill and judgment bring like financial rewards to the unusually skillful?

At the other extreme are the young practitioners recently graduated who under the present system often have to serve for several years with relatively meager earnings. Would compulsory insurance increase their earnings in the early years? Would it increase them more than payments for services rendered under State plans with Federal aid?

Could the Government adjust fees for services on the basis of the skill, experience, and reputation of practitioners, and if so how would it determine who should have the services of the top men?

EFFECTS ON QUALITY OF MEDICAL CARE

Both practitioners and consumers have a deep concern for maintaining and advancing the quality of medical care. It may be assumed that among the poorer people in less privileged areas of the country either plan would increase the quantity of medical care and presumably in many instances its quality. The major issue on this point is therefore:

> What would be the effect of compulsory insurance on the quality of medical care for those persons whose means are such that they could not take advantage of the subsidies paid under the grant-in-aid plan?

The subquestions under this major one relating to the quality of medical care are:

> What, if any, real substance is there to the assertion that compulsory insurance impairs the relationship between patient and practioner?
>
> Do systems of per capita payment or salary payment lead some practioners to treat patients superficially and summarily?

A compulsory insurance system as a rule greatly increases the number of calls on practitioners, and many of these calls are in connection with minor ailments, perhaps even fancied ailments. Many such patients would not have a doctor if they had to pay a fee. Does the presence of a substantial number of patients of this type waste the time of the practitioner and encourage him to deal summarily with many patients? Are some practitioners paid on a fee-for-service basis under a compulsory system likely to encourage patients to come repeatedly when there is no real need for it?

GOVERNMENT CONTROL AND QUALITY OF SERVICE

Closely related to the question of quality of service is another major one, arising from the fact that a large measure of governmental regulation and control is inherent in compulsory health insurance. The broad question may be phrased:

> What effect will control and regulation of the medical profession have on the quality of medical care?

Among the more specific questions under this general one are:

> Will the system result in the selection and designation of specialists exclusively on the ground of merit without reference to partisan politics and professional politics?[2]
>
> Will the administrators directly or indirectly enforce standard practices and techniques which must be largely accepted by specialists and general practitioners?

This question may be made more specific by further subordinate questions:

> Can administrators distinguish between practices and techniques fully established by science and those based on judgment? Will administrators attempt directly or indirectly to impose their judgment on practitioners whose judgment is in conflict with theirs? Where there is a radical treatment and a conservative treatment, will the practitioner be free to use his best judgment?
>
> Will the administrators be free to rule that so-called health cults are barred from participation in insurance funds even if both professional and lay opinion are divided as to their value in certain types of cases?
>
> Will the administrators be free to control self-medication and the so-called patent-medicine business by regulating the preparations that may be used by insurance practitioners and forcing persons who would use other preparations to pay for them from their own funds?
>
> Will insurance practitioners be strictly regulated with respect to the prescription of alcoholic liquors and narcotics in the treatment of patients?

THE AVAILABILITY OF PERSONNEL

The existence of a belief in some places that the passage of a compulsory health insurance law would immediately make available to everyone adequate health services necessitates consideration of a major question:

> Does the United States now have enough qualified general practitioners, specialists, nurses, dentists, and other practitioners or facilities to assure adequate medical care to everyone?

In the case of dentistry it is clear that there is a tremendous backlog of dental work if all adults should have all the dentistry done that they need for the most advanced care of the teeth. How long would it take the Nation to train a sufficient body of dentists to clear that backlog within a reasonable length of time? With the great improvement in dental care for children that has been taking place in this country in recent years and will presumably continue under either plan, and with the backlog of accumulated dental work cleared away, would there be a surplus of dentists?

ADMINISTRATIVE COSTS AND PROBLEMS

Either plan would require additional personnel for its administration—personnel which would not be directly engaged in rendering medical care to the people. Thus there is a major question:

> How would the administrative costs of the grant-in-aid plan compare with those necessary under compulsory insurance?

A compulsory-insurance system under which practitioners are paid on a fee-for-service basis has two weaknesses: (1) a great increase in number of calls or services, and (2) heavy expenses for accounting and auditing. If a compulsory-insurance system is adopted, will these two weaknesses force the abandonment of the fee-for-service system and the substitution of per capita or salary payments?

---

[2] By professional politics is meant support of, or opposition to, the members of the profession who are connected with the administration of the system.

Administrative costs can obviously be reduced materially by the use of the per capita method or the salary method. To make the per capita method administratively practicable, it appears necessary to require (*a*) that the insured select his general practitioner and get on his list at the inception of the system, in some instances, when there is not and has not been for a long time any illness in the family that resulted in medical care, and (*b*) that the patient's privilege of changing doctors be restricted to ends of accounting periods, such as quarters and half-years or years. To what extent do these administrative solutions represent impairment of freedom in choosing physicians?

Salary payment of practitioners means so far as pay is concerned simply the application of the already well-developed accounting methods of pay-roll disbursing. It necessitates, however, the administration of far more difficult tasks: (1) Creating the positions deemed necessary to give adequate medical care to the population of the area covered or to the group included; (2) determining the salary range for the position; (3) selecting the individual who is to fill the position; (4) appraising or attempting to appraise the efficiency of the employee periodically so long as he remains in the position; and (5) establishing mechanisms for receiving and acting upon complaints and charges against the employee whether they come from dissatisfied patients or from professional or administrative supervisors or inspectors. In small communities or in sparsely settled rural areas the insured would have practically no alternative to utilizing the services of the salaried employee assigned to the area or the group by the Government. Provision of choices in personnel would greatly increase cost of service.

The question must therefore be raised as to whether administrative costs of compulsory insurance would tend gradually to force the abandonment of the fee-for-service system, and the extension of the per capita or the salary system. A related question is, If compulsory insurance is once introduced and fully organized under government, can the people turn back to the old system or are the forces such as to increase rather than diminish government control and operation?

Distribution of costs

The expenditures for medical care would without question be substantially increased by the adoption of either plan. Part of this increase would result from administrative costs and part from giving medical care where it is not now received and increasing the amount given. An important question is therefore:

> How is the increased cost of medical care to be distributed?

Under a plan that makes free care or care at much less than cost available only to the indigent or the medically indigent, it is obvious that the beneficiary at the time of his need cannot pay the costs. Where would the money come from to pay these costs? Would much the same sources have to be used to pay for the services under a compulsory insurance plan? Under such a plan the amount of money collected and disbursed by the Government would be far greater than under the one limited to the indigent and the medically indigent. What forms of taxation would be available to raise the necessary funds?

THE MEANS TEST

The compulsory insurance plan does not require the use of the means test, except possibly with respect to the indigent who cannot pay such taxes as may be required to establish rights under the system. The grant-in-aid system to provide for the indigent and the medically indigent necessitates the use of the means test. A dividing line or a dividing zone has to be established between those eligible for free service or service at less than cost and those who will be required to meet their own costs.

> Could a means test be so devised as to operate on a basis of contingent rights under law, which become effective on fulfillment of the contingencies prescribed? In other words, could the element of administrative discretion be largely eliminated?

ADMINISTRATIVE STRUCTURE

Either of the two plans would necessitate new or expanded administrative units in the National Government. Health and the need for medical care are related to education, employment, and social services.

> Should there be an independent agency for health services or should health services be incorporated with related agencies?

This introductory chapter has broadly outlined the major issues, it is hoped in sufficient detail to make them reasonably clear. In the ensuing chapter (of the full report) each of the issues will be taken up in turn and considered in summary form. Questions which are primarily factual can be answered fairly definitely but not in detail or with nice qualifications. Others which involve primarily opinions and economic, social, and governmental philosophies will have to be treated by analysis of the pros and cons. Subsequent chapters (of the full report) will deal with individual major questions.

II. Conclusions and Recommendations

The purpose of this chapter is to give in summary form and without supporting argument and data, the conclusions and recommendations that have resulted from the study. The discussions and data will be found in other chapters (of the full report).

Before summarizing the conclusions and recommendations it may, however, be well to enumerate briefly the main elements in the foundation upon which they rest. These elements are:

1. An analysis of the major issues involved in changing existing arrangements for the provision of medical care to individuals. This analysis was made mainly through an extensive examination of the literature in the field.
2. Examination, appraisal, and analysis of the major bodies of factual evidence, mainly statistical, that bear on such of the issues as are essentially questions of fact.
3. Application to many of the issues of the knowledge and judgment gained by the Institution or by members of its staff who have worked on this project through earlier activities. Three particular types of such activities deserve mention:
    - (*a*) Intensive studies of government and its administration, including functions, activities, and procedures of the National Government and surveys of State Governments and their administrations;
    - (*b*) Statistical studies in the fields of population and vital statistics, and in the social and economic problems related to these fields;
    - (*c*) Experience in administration and research in the fields of public health, control of diseases, and medical relief. In this connection, however, it should be noted that the present study has been confined to social, economic, and governmental issues, and no attempt has been made to treat strictly medical problems.

CONCLUSIONS

The conclusions based on this foundation are:

1. Probably no great nation in the world has among its white population better health than prevails in the United States. A few small homogeneous countries, such as New Zealand with respect to its white population, are slightly ahead of the United States as a whole, but certain States of the United States with larger populations equal them.
2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care.
3. The nonwhites in the United States have materially poorer health than the whites, but the evidence does not indicate that this condition is primarily or even mainly due to inadequacy of medical care.
4. The advances in health among both the whites and the nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system.

5. Although the statistics resulting from the administration of the Selective Service Act—the so-called draft statistics—have been widely used to show bad health among the American people and the need for revolutionary changes in arrangements for medical care of individuals, they are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole.

6. Present medical care in the United States compares favorably with that which existed in other leading nations prior to the Second World War.

7. The conditions in extremely poor rural areas that lack the resources to support adequate public services, such as health work, education, and highways cannot be satisfactorily solved by subsidies. This problem calls for a radically different approach, either bringing in new or improved economic activities or getting the people to more favorable and administratively less expensive areas. This condition has been accentuated by the emigration of youth from these areas to urban communities.

8. The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status. The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements.

9. Compulsory health insurance would necessitate a high degree of governmental regulation and control over the personnel and the agencies engaged in providing medical care. This field of regulation and control would be far more difficult than any other large field previously entered by the Government, and past experience with governmental regulations and control in the United States causes doubt as to whether it encourages initiative and development.

10. The problem of eliminating politics from Government administration is extremely difficult. It does not seem probable that politics could be eliminated from medical care supplied under a governmental system.

11. Compulsory insurance would inject the Government into the relationship between practitioner and patient. A real danger exists that Government actions would impair that relationship and hence the quality of medical care.

12. The administration of compulsory insurance would require thousands of Government employees for accounting, auditing, and inspection and investigation.

13. The cost of medical care presumably would increase because of (*a*) administrative expenses; (*b*) the tendency of insured persons to make unnecessary and often unreasonable demands upon the medical care services; and (*c*) the tendency of some practitioners and agencies to take advantage of the system for their own financial advantage.

14. The adoption of compulsory insurance would not immediately make available adequate service for all, because there are not at present the facilities nor a sufficient number of trained and experienced physicians, dentists, and nurses to meet the demand which would result from compulsory insurance.

15. Proposals for compulsory insurance provide for payment of practitioners under one or all of three methods: (*a*) fee for service, (*b*) per capita, or (*c*) salary. Use of the fee-for-service device represents the minimum degree of socialization, but it is administratively difficult. Administrative difficulties would probably result in the adoption of the per capita system which represents a higher degree of socialization or even in the salary system which represents practically complete socialization. It seems questionable whether a country which once embarks on compulsory insurance can turn back but must attempt to remedy defects by more complete government control and administration.

RECOMMENDATIONS

1. For the present, in our judgment, the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted or whether the provision of professional services is to be left in the realm of free enterprise. It seems highly probable that in many communities the intelligent cooperation of consumers and practitioners will develop satisfactory arrangements that remain subject to their own control without National Government administration. It seems highly improbable that this experimentation—possible under our Federal form of government—will ultimately develop a single pattern that is applicable to all sections of the country and is desired by a large majority of the people. If such a pattern should develop, it will doubtless then be adopted with a great degree of unanimity. If compulsory insurance should be adopted now by a narrow vote in the Congress, thousands of persons who are opposed to it would start hostile to the whole undertaking.

2. For the time being the National Government and many of the State governments may well devote their resources and energies to:

(*a*) Research and developments in the fields of public health;

(*b*) Health education at the school level;

(*c*) Teaching of preventive medicine;

(*d*) Assisting in the acquisition of physical facilities and training of personnel;

(*e*) Providing systematic care for the indigent and the medically indigent. In Some States careful surveys of existing conditions will be required to furnish the basis for developing a comprehensive and coordinated program.

3. From the standpoint of public relations, governments might be well advised to leave adult educational campaigns for the control and prevention of disease to the national, State, and local voluntary organizations which have been able to enlist the active cooperation of leading laymen in most sections of the country. It must be remembered that good health is not exclusively a matter of medical care; it also impinges upon causative factors that are nonmedical, such as food, shelter, vice and crime, transportation, and industry. Its maintenance depends also upon the intelligence, interest, and cooperation of individuals, families, and local communities.

These recommendations are not widely at variance with those of the majority of the Committee on the Costs of Medical Care, arrived at in 1932 after a comprehensive study. The report of the committee says:

"* * * [The] majority of the committee does not endorse the recommendation which would make health insurance a legal requirement for certain sections of the population. These members realize that such a step may ultimately be necessary and desirable in some States, but they believe that for most States and probably for almost all of them at the present time, it is much more desirable (*a*) to encourage voluntary measures for protection against wage loss during sickness, and (*b*) to develop voluntary insurance for medical care in conjunction with group practice, with hospital service, and with the related measures recommended on the preceding pages. They are of the opinion that the difficulties of these plans can be controlled by a combination of professional and community effort, and that these plans hold the promise of steady extension in scope of service and in proportion of the population served. These members believe that the various payment plans (aside from compulsory insurance) if fully carried out, would: (1) largely solve the problem of hospital costs which constitute about 50 percent of the average family expenditure for the care of sickness; (2) provide adequately for many rural areas in which serious deficiencies of facilities exist at present; (3) make more nearly adequate provision than exists at present for the "indigent" and for the care of certain diseases of public importance; and (4) provide, through voluntary cooperative insurance * * * medical service to a majority of the 70,000,000 people living in industrial communities and in cities."[3]

The years since 1932 have witnessed—

1. A great growth in voluntary insurance both for hospitalization and for medical services.

2. State experimentation with compulsory health insurance in Rhode Island and California.

---

[3] Medical Care for the American People, the final report of the Committee on the Costs of Medical Care, October 31, 1932, p. 130.

3. A growing willingness on the part of practitioners to cooperate in the development of prepayment plans and other devices to enable patients who so desire to regularize their payments for medical care.

4. A profound change in the amount and distribution of the earnings of the American people. This change greatly reduces the number who cannot afford adequate medical care if they desire to purchase it.

The experience of the United States since 1932 seems to have demonstrated the wisdom of these recommendations of the majority of the members of the Committee on the Costs of Medical Care. It would seem unwise at this time to substitute for these developments a system of compulsory health insurance by national law which would have the unfortunate tendency to freeze policies and eventually retard medical progress.

(Whereupon, at 1:50 p. m., the subcommittee adjourned until 10 a. m., Wednesday, May 26, 1948.)

(Pursuant to Senator Murray's letter of p. 2525, a review of the report of the Brookings Institution by Michael M. Davis and Dewey Anderson appears as follows:)

"MEDICAL CARE FOR THE INDIVIDUAL" AND "THE ISSUE OF COMPULSORY HEALTH INSURANCE"

A REVIEW OF THE REPORT OF THE BROOKINGS INSTITUTION BY MICHAEL M. DAVIS, CHAIRMAN, COMMITTEE ON RESEARCH IN MEDICAL ECONOMICS, NEW YORK, AND DEWEY ANDERSON, EXECUTIVE DIRECTOR, PUBLIC AFFAIRS INSTITUTE, WASHINGTON

This pamphlet is being published at the request of Senator James E. Murray and Senator Claude Pepper, members of the Subcommittee on Health. The opinions expressed herein should in no way be construed as representing the official views of either the Subcommittee on Health or the Senate Committee on Labor and Public Welfare.

LETTER OF TRANSMITTAL

JUNE 3, 1948.

Senator H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Labor and Public Welfare Committee,
United States Senate, Washington 25, D. C.

DEAR SENATOR SMITH: We beg to transmit to you a report which has been prepared at our request on the reports of the Brookings Institution, Medical Care for the Individual and The Issue of Compulsory Health Insurance. Believing that these reports justified careful analysis by persons expert in the subject, we asked Michael M. Davis, Ph. D., chairman, Committee on Research in Medical Economics, New York, and Dewey Anderson, Ph. D., director, Public Affairs Institute, Washington, to prepare such an analysis. It is transmitted to you herewith and with the request that it be published as a committee print as was the first Brookings document, Medical Care for the Individual.

The review made by Drs. Davis and Anderson shows clearly that many of the difficulties alleged in the Brookings reports against compulsory health insurance plans apply also to voluntary health insurance plans. Their review also shows that the elaborate parade of statistics which fills a large part of the main Brookings report has no relevance to the central issue under discussion, namely, "Is health insurance desirable and necessary as the way of paying the costs of medical care?"

When we examined the preliminary Brookings report published 4 months ago, it seemed to us an attack on compulsory health insurance which, however, not only accepted the principle of health insurance as such but which also advocated voluntary health insurance as the "American solution" of the economic problems of medical service. On examining the review made by Drs. Davis and Anderson of the 200 page Brookings report recently issue, and on checking back to this report itself, we were amazed to find that the Brookings authors accept compulsory insurance after all. They are so doubtful whether voluntary health insurance will be acceptable to a large proportion of our people that they tuck away among their final pages the proposal that the American people be compelled by law to join "voluntary" health insurance plans.

Unfortunately for these gentlemen, the kind of system which they propose would be costly, confusing, and would compel government to take on the very kind of regulation of medical service which is obnoxious to physicians and which is condemned on other pages by the same authors themselves.

We invite you and all other members of the Senate Labor and Welfare Committee to study with care the Brookings report itself and the thorough analysis which we send you herewith.

Sincerely yours,

JAMES E. MURRAY.
CLAUDE PEPPER.

JUNE 4, 1948.

Senator JAMES E. MURRAY,
Senate Office Building, Washington 25, D. C.

MY DEAR SENATOR MURRAY: In your letter of April 5, 1948, you enclosed a document entitled "Medical Care for the Individual" which represented a portion of a study undertaken by the Brookings Institution at the request of Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare. You indicated that the Committee on Research in Medical Economics and the Public Affairs Institute might be professionally qualified to undertake an objective analysis of that document, and asked that we furnish you with a report of our analysis.

We have not only analyzed that document but have carefully studied the full text of the Brookings Institution report just published, entitled "The Issue of Compulsory Health Insurance," on which the original document was based.

We have the honor of herewith transmitting to you for your use and for the information of your colleagues, as well as such individuals and groups as might be interested, a summary report of our analysis.

In view of the very apparent and widespread public interest in the Nation's health and in various proposals for meeting national health problems, we trust that our report may be of some value.

Sincerely yours,

MICHAEL M. DAVIS,
Chairman, Committee on Research and Medical Economics,
DEWEY ANDERSON,
Executive Director, Public Affairs Institute.

MEDICAL CARE OF THE INDIVIDUAL AND THE ISSUE OF COMPULSORY HEALTH INSURANCE

The Brookings report, which we have been asked to review, falls into four parts—first, The Issues are stated; next comes Analysis of the Evidence; third, The Evidence itself; and fourth, Conclusions and Recommendations. Of the 219 pages in the book, 144 pages are given over to The Evidence. Since the numerous facts therein presented presumably provide the basis for Brookings' conclusion that a program of national health insurance should not be adopted, we may well begin by examining this evidence.

THE EVIDENCE

It is curious and rather startling to find that these 144 pages of evidence contain no facts at all on the chief subject with which the report is concerned, namely, health insurance itself. Instead The Evidence is devoted to statistics on five subjects—

1. Mortality, i. e., international comparisons of death rates and expectation of life; comparisons among our 48 States, and between whites and nonwhites.
2. Selective-service examinations.
3. Illness and medical care.
4. Capacity of people to pay for medical care.
5. The supply of doctors, dentists, nurses, and hospitals in this country.

True, in that part of the book entitled "Analysis of the Evidence," covering 51 pages, 21 pages analyze the statistical material just referred to, while 30 pages are devoted to a so-called analysis of health insurance. Conclusions unfavorable to national health insurance are drawn.

But where is the evidence on which this discussion is based? Nowhere does there appear any facts about the actual experience of voluntary and compulsory health insurance plans, as to their methods of operation, costs, administrative provisions, and the relation of these provisions to the scope and quality of care and to the remuneration and opportunities of the medical practitioners and hospitals.

On these subjects a vast amount of experience has been gathered by the voluntary health insurance plans in this country. A number of these have been operating for 20 years or more; some for much longer periods. Even the voluntary health insurance plans that have grown up rapidly within the last dozen years have already made a mass of experience available. In all countries of Western Europe, from Scandinavia and Great Britain south to Italy and east into the Balkans, both voluntary and compulsory health insurance have been working for a half century and more. Altogether, the descriptive and statistical material on the operation of health insurance plans is a library in itself.

The Brookings Report contains nothing of this. It gives no indication that the European experience has been studied at all. As to the American experience it is said, "Although a considerable volume of literature regarding these voluntary (health insurance) devices has been examined in the course of the present study, no attempt has been made to describe them or to present statistics regarding them. The advances in this field are so rapid that reports are out of date almost as soon as they are published (p. 39)." The last sentence must refer to the recent "advances" in number and membership of certain types of plans. It cannot mean the methods of organization, operation, and finances of these and other types of plans from which experience has accumulated that is in no way "out of date."

In a word, the report's discussion of its main subject, i. e., The Issue of Compulsory Health Insurance, is not based on any statement of facts or any analyzed body of experience. It is not surprising, therefore, that many of the "conclusions" on examination prove to be erroneous. Let us take a few illustrations.

PROBLEMS INCIDENT TO ALL HEALTH INSURANCE PLANS

Brookings set forth several problems which it believes inherent in a compulsory health insurance program and which it concludes are so grave as to render such a program undesirable. Among these are problems of administrative costs, regimentation, the capitation system of payment, and bureaucracy. We shall discuss each of these. But first we must state without qualificaion or equivocation that every one of the strictures levied at a compulsory health insurance plan by Brookings because of the existence of these problems is much more applicable to our limited, privately controlled, voluntary plans. If the existence of these problems leads Brookings to oppose compulsory health insurance, then Brookings cannot but conclude that voluntary health insurance plans are also undesirable. This it nowhere does. That the problems do exist, both in compulsory and in voluntary plans, is undeniable. But they have been known for a long time; we have accumulated a wealth of experience in dealing with them; they are easily controlled; and they are, in any case, relatively minor matters in no way calculated to offset the tremendous values of health insurance programs whether voluntary or compulsory. All of which would have been readily apparent to the Brookings researchers had they included in their evidence the actual experiences of health insurance plans.

Let us look at some of these problems.

The problem of administrative costs

Brookings mentions that administrative costs would be high under compulsory health insurance (p. 57). As an example of costly red tape the procedures required of physicians (if paid fees for services) are described:

"Practitioners under the system must necessarily (1) maintain records of all services rendered under the system, classified in accordance with the rate schedule; (2) multiply the rate allowed for each service by the number of times the service was rendered; (3) enter any other items for which they are entitled to compensation; and (4) add the amounts of the several items, and thereby arrive at their claim against the Government. The chances for errors are so great that the Government will require a staff of auditors and auditing clerks to check the claims. As the payments to the practitioner will vary from month to month, or quarter to quarter, the amount of payment will have to be entered by relatively slow mehods on each individual check and the checks will have to be individually verified. All this procedure is routine" (pp. 57–58).

One would think from this statement that some such procedures had to be performed only under compulsory health insurance. Apparently it never occurred to the authors that, in their private practice today, physicians have to maintain, with the aid of their wives or secretaries, or with their own hands, a record of their visits, operations, and other procedures for each patient. They have to make up their bills, exactly as is described in clauses Nos. 1–4 in the preceding quotation, with the exception that in private practice the last words, "their claim against the Government" would be changed to read "their claim against each patient." Unless physicians are paid cash by the patient at the time of an office or home visit, physicians have to make up bills for each patient, usually monthly. They have to mail as many bills as they have had patients during the preceding month. Often they do not itemize the bills sent patients, but they must have the items on their records and must go through the computations above stated, in order to make up the amount due.

Suppose the physicians are to be paid from a voluntary health insurance plan. Such physicians, when paid on a fee-for-service basis, have to keep the same kind of records, and go through the same procedures in order to prepare their bills against the plan. Moreover, the office of any insurance plan, whether voluntary or compulsory, will haveg to go through the procedures described in the last part of the Brookings quotation, if it pays its doctors by fees for service.

The administrative costs incident to such highly desirable record keeping would be less under a comprehensive, compulsory health insurance system than under the limited voluntary plans which would seem to be our only alternative.[1]

Regimentation

Another paragraph in the report is intended to display the regimentation which Brookings feels will characterize compulsory health insurance.

"The Government cannot, however, safely assume that all practitioners and agencies having claims against the insurance fund are honest. No profession or calling is without its delinquents. Thus claims against the Government fund will be submitted for services not actually rendered, for services allocated to higher categories in the schedule than should have been used, unnecessary services, prescriptions that violate the regulations, and probably many others. Some collusion to defraud is inevitable between claimant and person treated and between claimant and suppliers. If costs are to be kept within reasonable bounds, accounting and auditing must be designed to reveal frauds and suspicion of fraud. Then come the inspectors and investigators, some handling routine matters and others of the detective type" (p. 58).

Again the authors ignore the fact that a voluntary insurance plan has to deal with exactly the same problems which this paragraph describes. The literature is full of discussion of these abuses, actual or potential, and of methods of controlling them. Some voluntary plans have been successful in controlling them even when doctors are paid fee for service. Some voluntary plans controlled by the doctors themselves have not controlled them sufficiently. But once again the point is that the existence within the medical profession of the usual proportion of delinquents does not present an insufferable problem nor does it necessitate "regimentation." Answers to the problem have been found. They can be applied.

In this connection it is worth pointing out, as indicative of the thoroughness of Brookings' research on this problem, that the central office of the Veterans' Administration in Washington is but two streets removed from the Brookings

---

[1] In view of the recent agreement at the National Health Assembly concurred in by representatives of the American Medical Association and set forth below on page 14.

Institution. For some 2 years now, doctors throughout the country have been billing the Veterans' Administration for services rendered under the Veterans' Administration's home-town-care plan. There is no doubt that the abuses mentioned by Brookings have occurred in that program. We have no knowledge as to how effectively they have been controlled. But we do know, and Brookings should, that most medical societies in the country are enthusiastically cooperating in that program and that the cry of regimentation has not been heard. If regimentation has not developed in that program—a form of State medicine under centralized authority—it is absurd to insist that it must appear in a highly decentralized, locally controlled national health insurance plan.

Capitation and free choice

The report discusses the payment to doctors by the per capita method, i. e., an agreed amount to a practitioner per year for each person who has chosen this physician as his regular medical attendant. The report does not describe this system correctly. It says:

"Each person covered will be allocated to a general practitioner" (p. 58).

By ignorance or design, the wording implies that an official decides what doctor each patient shall have. Actually each person chooses his doctor and has the absolute right under the law to do so. This is true of every one of the national health insurance bills introduced into Congress of recent years. It is true in the health-insurance law of England, the country which has had the longest and most extensive experience with the capitation system. The actual practice in England has assured free choice, and also free and easy change of doctor when the patient desires. The Brookings report incorrectly implies (p. 58) that change of doctor must be hedged with restrictions. This is not true. There is ample evidence to the contrary.

Bureaucracy

Again (on pp. 58–59) Brookings invokes the fear of bureaucracy, red tape, and regimentation as an argument against national health insurance. It states that, "A practitioner may neglect a patient or at least appear to the patient to be neglecting him. From the patient's point of view the insurance system is not rendering the service that he has a right to demand. He may become so disturbed that he files an official complaint. Then follow the familiar administrative processes—complaint, investigation, hearing, decision, and perhaps penalty and enforcement of penalty" (pp. 58–59).

And again Brookings has done no more than to overemphasize a problem common to both voluntary and compulsory health-insurance plans and one for which reasonable solutions have long since been developed. As a matter of fact, looked at from the patient's point of view—and after all it is the patient's health and the patient's money which are at stake—the situation described might well be considered an advantage rather than a problem. For it is only as a member of a health-insurance plan, voluntary or compulsory, that the patient finds readily available machinery through which complaints can be adjusted. His only recourse in the absence of an insurance plan is in litigation so long-drawn-out and expensive as to be prohibitive. So what to Brookings may constitute a serious draw-back in insurance plans may be of positive value to the great number of honest, conscientious doctors and to their patients.

Government control

In the endeavor to prove that compulsory health insurance would lower the quality of medical care, the report says that "the introduction of compulsory health insurance opens the way for governmental control of the medical profession * * *. Under the compulsory insurance system, the Government must determine who is qualified as a specialist in a particular field and entitled to receive specialist fees" (p. 51).

In the first place, a voluntary health insurance plan must do exactly the same thing. If it pays its doctors on a fee-for-service basis, it must have committees and officials to determine which doctors may be paid at rates appropriate to specialists. If the voluntary plans do not maintain such standards—and some such plans do not at the present time—the plans fail at a vital point.

Compulsory insurance plans have to deal with exactly the same problem. The national health insurance bill requires that decisions concerning the qualifications of specialists must be made by qualified professional bodies.

Politics

The Brookings report dwells much on a difficulty which compulsory plans do face and from which voluntary plans are supposedly free. This difficulty is described as the politics and inefficiency alleged to be connected with all governmental administration.

To a large extent the report proceeds on the assumption that health insurance administration would be centralized in the Federal or in a State government. The authors apparently do not know or will not say that no health insurance plans providing comprehensive physician services have been successful unless the responsibility for administration was largely local. This is true of both voluntary and compulsory plans. Once the administrative set-up is such that a large degree of local responsibility is assured, most of the difficulties described in the Brookings report disappear.

Analysis of the bills before the Congress and with reference to which the Brookings report was supposedly made indicates that the sponsors of the national health insurance bill, S. 1320, were well aware of this problem and of its solution. For S. 1320 places strict limits on the powers of the Federal Government and delegates the real responsibility for the administration of medical care plans to local areas. The Federal Government's functions under S. 1320 are limited to the collection of funds, the allocation of these funds to the States, according to a formula stated in the bill, and the making of certain general standards. Neither doctors nor patients, under this national health insurance scheme, would have any contact with the Federal Government and only rarely would they have contact with their State government.

Thus it is apparent that the problems which Brookings raised as incident to and arguments against compulsory health insurance are either not problems at all or apply to voluntary plans as well as to compulsory plans. If the Brookings' authors had made any serious study of voluntary insurance plans in this country or abroad they would have known it.

PROBLEMS OF VOLUNTARY HEALTH INSURANCE PLANS

We have stated that the Brookings report carefully refrains from indicting voluntary health insurance plans. And, in view of the recent growth of such plans and of the American Medical Association's all-out endorsement of the value of such plans, such an indictment would have been fatuous in the extreme. But since Brookings did undertake to attack compulsory health insurance because it presented problems we have shown to apply to voluntary plans as well, it seems desirous that we point out some additional problems which are inexplicably overlooked by Brookings and which give compulsory health insurance a decided advantage over voluntary plans.

Sales overhead

Voluntary insurance plans face one type of administrative problem with which compulsory plans do not have to deal. The compulsory plan does not have to "sell" the health insurance to people, or to keep members up in their payments, as voluntary plans do; because the payments are collected through pay-roll deductions or otherwise, along with other social-security payments or with other taxes. In other words, the problems and costs of sales promotion do not have to be dealt with by a compulsory plan. These costs run between 7 and 10 percent, even under favorable circumstances; much more in some types of voluntary plans. Nowhere in the Brookings report is this difference in favor of the compulsory system mentioned.

Geographical limitations

Still another problem which voluntary plans have not been able to solve and which would be nonexistent under a national health insurance plan is that of making the same or comparable coverage available to the insured throughout the Nation. In a country with a population as highly mobile as ours this is extremely important. Even more important, however, is the difficulty which this problem poses for the Nation's large industrial or business concerns. More and more they are finding it of value to themselves to assist in providing medical-care inurance for their employees and their dependents. But for those concerns with plants in various States or whose employees cross State lines in the course of their employment, the multiplicity of limited voluntary plans, each with different coverage and different rates, presents a serious problem. It is true that the Blue Cross seems to be making progress in the solution of this problem as regards insurance for hospital care but no progress has been made nor does it seem likely that any will be made as regards voluntary medical-care insurance programs.

The collective-bargaining problem

In this same connection mention should also be made of the face that large employers whose workers are represented by more than one union are confronted by an almost insuperable problem in trying to set up sound health insurance plans. Such an employer can rarely find a single medical care plan to serve his employees. Even if he could, he would still find it difficult if not impossible to develop an efficient plan so long as the continued acceptability of that plan was dependent on a series of collective-bargaining agreements entered into at different times and with various unions. This situation represents one of the knottiest problems in today's labor-management picture. It is arising more and more often. We believe it obvious that it cannot be solved save by removing the question of medical-care insurance from the field of collective bargaining entirely. And that can be done not through any conceivable development in voluntary plans but only through an expansion of our social-security system which will include a national health insurance system.

Other limitations of voluntary plans

Space will not permit our discussing at length the many other disadvantages of voluntary plans, which should have entered into the Brookings evaluation but did not, such things as the duplication of facilities and of personnel, the multiple and conflicting sets of rules and regulations, the different accounting procedures required, and the varying degrees of responsibility which characterize our mélange of voluntary plans. Mention should be made too of the great difficulty faced by voluntary plans in adjusting rates to fluctuating costs—a difficulty now creating serious differences between the Blue Cross and its member hospitals; a difficuty solved in S. 1320 by the provision whereby the Federal Government would at any time make up the difference between what our families can afford to pay for medical care and what it costs to give that care.

Finally, mention should be made of the fact that our voluntary plans, because they charge their subscribers all the same flat rate, of necessity violate one of the oldest and best rules of American medical economics. American medicine has been rightfully proud of the principle under which a doctor varied his fee in accordance with the patient's ability to payy. But our voluntary plans do just the reverse. If they offer limited medical and hospital insurance at $50 a year, they are asking for 5 percent of the income of a family with a thousand a year to live on but only 2 percent of its income from the relatively well-to-do family with $5,000 a year. Should those families seek anything like the more comprehensive coverage sold approximately at $100 a year, the poor family must offer a staggering 10 percent of its income while the wealthier family pays but 2 percent. Voluntary plans cannot do otherwise. Only a system of health insurance with payments graduated in accordance with income can resolve this difficulty. Such a system is usual under compulsory health insurance, as proposed for the State of California by Gov. Earl Warren, or for the United States in the pending national health insurance bill (S. 1320).

THE DOCTOR SHORTAGE

The report declares that compulsory health insurance would not work because there are not enough doctors to provide the greatly increased services which the authors believe would be demanded by the people. So, also, with dentists, nurses, and hospitals.

As to dentistry and nursing, no health insurance law has been proposed that would include more than very limited dental and home nursing services, if any at all. The portions of the report referring to dentistry and nursing do not mention this fact. A national policy, in which Federal funds assist States and localities, is already established to correct the hospital shortage.

The report presents some evidence (pp. 191–202) about the supply of doctors. Expert opinions differ as to whether there is a doctor shortage, present or prospective. Some well-known medical educators believe there is not (p. 191). The American Medical Association holds that the present output of graduates from medical schools is sufficient to maintain an adequate supply of physicians. On the other hand, the United States Public Health Service estimates that some 30,000 more physicians are or soon will be needed.

There is no disagreement that doctors are not well distributed. In proportion to population there are too many in the cities and too few in rural areas. For the poorer rural areas, where the shortage of doctors is most acute, the Brookings report has no remedy to propose except "bringing in new or improved economic activities," or moving the people out to other areas. This is a counsel of despair so far as medical service is concerned.

As to the effect of the shortage of doctors, if there is one, upon the success of compulsory health insurance, the writers of the report apparently did not not examine the national health-insurance bill (S. 1320) to see the special provisions which it offers to assist rural areas in getting and retaining physicians.

If there is no doctor shortage but only a maldistribution of physicians, then national health insurance by guaranteeing payment for services wherever rendered will be a most powerful factor in correcting that maldistribution. If there is a shortage of doctors, then by converting need for medical care into an effective demand for medical care, backed by the ability to pay for it, national health insurance will both prove the existence of the shortage and at the same time provide the economic incentives needed to overcome it.

MEDICAL CARE OR STATISTICS

One-quarter of the entire Brookings report is taken up with a presentation of statistics on mortality and data from the selective-service examinations. The purpose of these statistics seems to be to ascertain (p. 23) "to what extent they reflect the health of the American people and the need for medical care," therefore, the need for health insurance.

International comparisons lead the Brookings report to the conclusion that "the United States occupies a very high position among the nations of the world with respect to the health of its white population" (p. 15). A review of National and State death rates leads to a similar conclusion, i. e., that the United States had made great progress in reducing mortality.

The selective-service statistics show high rejection rates of young men disqualified for military service because of disease and defect. These data are examined at some length in the report. Many inaccuracies and confusions are pointed out, due to various causes—including changing standards for the Army medical examinations. The conclusion is reached that these statistics "are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole" (p. 68).

Most of these statistical studies and "conclusions" are irrelevant to the main issue with which the report deals, i. e., health insurance, which is a way of paying the costs of medical care. The whole attitude of these sections of the report is to offer statistics and not think of individuals. Differences between whites and Negroes are, for example, examined in some detail. The health of Negroes, insofar as it is indicated by mortality statistics, is "far below that of the whites" (p. 88). But, asks the report, how far are these differences due to (1) race, i. e., hereditary factors; (2) "the way of life" of the people; or (3) medical care? (P. 101.) The report asks us "to recognize clearly that the problem is by no means exclusively one of individual medical care. Medical care by itself will not correct personal habits that result in disease and death. It is not a substitute for intelligent care, particularly of infants and young children" (p. 101).

Here is another unsound statement. One of the chief tasks of every physician dealing with children is to teach and guide their mothers. "Intelligent care" of young children by their parents and other members of the family depends largely upon medical care by well-trained physicians. And unless parents can afford to take their children regularly to physicians, as they could under national health insurance, they must perforce go without just that instruction in a proper "way of life" which Brookings believes important.

Certainly the "ways of life" of a family trying to live on $1,500 a year and a family with $5,000 to spend are different, and different largely because of the difference in income. There is an intimate correspondence between low income and a way of life that does not conduce to good health at any age.

The authors do not seem to be familiar with the long series of studies by the United States Children's Bureau and other bodies,[2] showing the differences in infant mortality that are correlated with economic status in different parts of the country. Still other studies have shown that within the same city, infant mortality is high in the areas filled by people of low income and low in better-off areas.

As to the selective-service statistics, it is true that they have sometimes been overused in an endeavor to demonstrate a "shocking" state of health among young American men. For the reasons cited in the Brookings report, the selective-service statistics are not a reliable measure of the health of young men or of the Nation as a whole. On the other hand, the report completely fails to recognize the fact that the selective-service data do have a real meaning for everyone interested in the Nation's health. After full allowances have been made for technical deficiencies in selective-service examinations, and after further allowances for those physical and mental conditions which could not be remedied, the fact remains that a large number of our young men were found to have diseases or defects which could be benefited by medical care and which would have been lessened or removed if the individual had received adequate medical care previous to the examinations.

---

[2] As references may be cited:

Green, Howard Whipple, Infant Mortality and Economic Status; Cleveland's Five-City Areas; 1909–37. 123 pp. mimeographed. Cleveland Health Council, Cleveland, 1939.

Wolff, George, Maternal and Infant Mortality in 1944; an Inquiry into Differential Mortality. U. S. Children's Bureau, Statistical Series No. 1. 17 pp. U. S. Government Printing Office, Washington, D. C., 1947.

Woodbury, Robert Morse, Casual Factors in Infant Mortality; a Statistical Study Based on Investigations in Eight Cities. U. S. Children's Bureau Publication No. 142. 245 pp. U. S. Government Printing Office, Washington, D. C., 1925.

Woodbury, Robert Morse, Maternal Mortality. U. S. Children's Bureau Publication No. 158. 163 pp. U. S. Government Printing Office, Washington, D. C., 1926.

Some of these conditions are very important to the welfare of the individual, whether he knows it or not. Some of them are of little importance. The individual may be partly or wholly to blame for neglecting his health. The reason for neglect may be ignorance, carelessness, fear of doctors, or fear of expense. Usually it is a mixture of more than one of these, but the last one is commonly present. The issue is not "who's to blame?" but "what can be done to cure or alleviate the diseases and defects found?" So far as concerns blame, both doctors and people are the victims of the situation rather than its cause.

From the selective-service statistics and from many other medical examinations made of presumably healthy persons, we learn that the present system by which we obtain and pay for medical care does not supply care in many instances where it is needed.

In the selective-service findings, for example, over 250,000 young men were revealed to have hernia during the single year 1945. Hernia is easily curable by surgery. Sometimes hernia is actually or potentially serious for the man who has it. Its seriousness will depend partly on the degree of the hernia and partly on the individual's occupation. The Brookings report never pictures an individual with human needs.

The general irrelevance of the report's statistical studies on mortality is illustrated by a remark by Mr. Oscar R. Ewing, Federal Security Administrator, in a recent radio debate with Congressman A. L. Miller.

Mr. Ewing. In certain parts of the country you do have the finest hospitals and the finest physicians, but with the last comparable statistics, in 1939, we stood tenth in general death rate, sixth in infant mortality, sixth in death from diphtheria, fifth in death from tuberculosis. We have a long way to go.

Mr. Miller. Is that bad? You are taking 60 nations in that program, and we are sixth among them. We are way at the upper top.

"Mr. Ewing. Why not be first?

"Mr. Miller. Today we are.

"Mr. Ewing. I beg your pardon, we are nowhere near where we should be, and the simple answer to that is, that we have certain sections of this country with good health conditions and others with bad. We can't be proud of our health program until we have wiped out the bad spots."

Contrast the Brookings attitude with the human statement from a recent book, You and Your Doctor, by Dr. Benjamin F. Miller, clinical professor of medicine at the George Washington Medical School.

"To pat ourselves on the back about American health by comparing it with health in other countries is a cruel and dangerous evasion of the issue. Our malaria record of 1,000,000 cases per year looks good compared with the astounding figure of 300,000,000 cases in the rest of the world. But it still indicates that we permit 1,000,0000 human beings to suffer unnecessarily from a preventable disease. Malaria is a major illness. Though not often fatal in this country, it causes great disability and anguish * * *.

"We should use only one yardstick to measure health. It must be based on the scale of what can be achieved at the present time. Our tuberculosis rate, for example, should be evaluated by what health experts report the minimum tuberculosis rate could be" (pp. 174–175).

And when we consider people rather than yardsticks, the same principle should apply. When more than 70 percent of our people cannot afford the medical care they have been taught by their doctors is necessary, it is useless to offer them statistics instead. The question raised by each of these families is not whether our average health is better than that of Timbuktu. They want to know whether their health is as good as it could be. The answer is "No." They want to know whether greater access to medical care will help make it as good as it might be.

ABILITY TO PAY

An essential part of the Brookings report is its attempt to prove that most people could pay for medical care if they tried hard enough to do so.

After devoting some 30 pages to this subject (pp. 35–38, 174–190) "it seems necessary," says the report, "to conclude that on the average lack of medical care among consumers with total incomes of around $2,000 or over, at 1941 price levels, is due more to failure to give medical care a high priority than to lack of resources to pay for it. Curtailment of luxury items in food, clothing, and shelter and reduction in expenditures for alcoholic liquors, automobile ownership and operation, tobacco, and recreation would permit a material increase in medical care" (p. 37).

In a later section (p. 185) this conclusion is broadened to refer to "most consumer units," not merely to those over $2,000.

Let it be noted that according to the table cited in the Brookings report on page 178, 65 percent of consumer units in 1941 had less than $2,000 money income. The proportion would be a little lower if income in kind as well as money income were considered. Nevertheless, among the rural groups, among whom income in kind is largest, only 25 percent of total incomes in 1941 were above $2,000.

Throughout the Brookings analysis of ability to pay there runs one fatal defect. Expenses for medical care differ from all other items in the family budget, because they are usually unpredictable as to when they will occur and as to how much they will be. The onset of acute illness or accident cannot be forecast, nor can a family tell whether the cost of treating it will be $5, $500, or much more. It is sometimes possible to budget in advance the cost of caring for a long-standing chronic illness but rarely with accuracy, because more or less acute stages requiring extra attention amy occur. In the main, sickness bills are an unpredictable and unbudgetable item in the family economy.

The characteristic failure to think in human terms is again revealed in the statement (p. 175) that "expenditures for acquiring, maintaining, and operating a car resemble closely, in some respects, those for medical care. The initial costs of a car may be likened to the cost incidental to the arrival of a new baby, although they are apparently on the average generally larger. In a high proportion of cases the costs of a car are spread through installment purchase. Once acquired, a car introduces into the consumer's budget an unpredictable element of costs. As in the case of medical care, months may elapse with no departures from normal functioning and no expenditures for repairs or replacements. Then accidents, lack of proper care, defects in material or design, or ordinary wear and tear may confront the consumer with heavy costs for repair or even with the necessity or the advisability of replacement. Some consumers have the resources to meet these unexpected costs from current income or past savings, but many meet them by installment payment or curtailment of other expenditures."

To most families who have or hope to have an automobile, for other than purely business purposes, a car is the source of a volume of positive and varied satisfactions. The incentives toward the purchase and use of a car are, therefore, strong.

It is quite otherwise with medical care. Medical care is not desired for its own sake by most people. It does not give enjoyment. When the need for it arises, it is an undesired necessity. During health, how can money for medical care be expected to have "priority" over the demands of current necessities and the lure of longed-for comforts? Particularly is this true because the unpredictable character of sickness costs makes it impossible to determine how much "priority"—measured in dollars.

The so-called unpredictability of automobile operating costs is much less in degree than with the costs of sickness. And the neglect or postponement of car repair cannot be compared, in its consequences, to neglecting or postponing needed care for a human being.

Then there is the matter of savings. In time of sickness families should draw on their savings. Many families have some savings. Many more should have. A table is presented (p. 182) showing that in 1941 the average percentage of income saved, for families with incomes over $2,000 a year, was as large as the average expenditures of families of this income group for medical care. Here again Brookings ignores the unpredictable and widely varying character of sickness costs. The figures of average sickness expenditure and average savings are wholly misleading.

About 40 percent of all the sickness expense borne by any group of families will fall in any one year on about 10 percent of the families. This 10 percent is unfortunate enough to have a good deal of illness during that year. There is no correspondence whatever between the existence of savings in a particular family and the occurrence or the amount of illness in that family. The evidence presented shows, moreover, that the actual amount of savings for the majority of American families is not sufficient to cover the cost of more than minor illness.

The report's talk about priorities and savings has no validity as proof that most people could meet the costs of medical care on a fee-for-service method of payment. All this talk, however, is thrown into the wastebasket by the report itself, in a buried paragraph (p. 185) which gives the reader to believe that a majority of American families could meet the cost of medical care on an insurance basis, out of their present average payments for medical care. Moreover, "if insurance does not materially increase costs," it is declared that many families could do this. Here is the basis for a health insurance program, but the report builds little on it. The fact is that, properly interpreted, the figures presented by Brookings show that the large majority of American families can pay for their medical care and without disrupting other phases of our national pattern of living. They can do this under one condition, namely, that they can purchase comprehensive medical care, available throughout the country, paid for on a budgetable basis in advance of illness, and paid for at a cost which is in proportion to their incomes.

BROOKINGS' CONCLUSIONS

The chief conclusions reached in the Brookings report are summarized in 15 paragraphs (pp. 67–70). Of these, the following would appear the most important:

"2. It is apparent that the United States under its voluntary system of medical care has made greater progress in the application of medical and sanitary science than any other country. This progress is now reflected in low mortality and morbidity rates of infectious diseases and increased life expectancy. There is every reason to believe that these trends will continue unabated under our present system of medical care."

This conclusion is irrelevant to the need for health insurance. The progress described actually increases the amount of medical care needed, because it results in a population having a larger proportion of persons in the middle and late years of life. Medical care may or may not bring a further increase in life expectancy. Such medical care is primarily for the purpose of maintaining the physical and mental health of individuals at the highest possible level during middle and late life. The larger amount of medical care required increases the need for a less burdensome method of paying for care than the traditional fee-for-service system.

Another main conclusion (No. 4) is as follows:

"4. The advances in health among both the whites and nonwhites that have been made in the United States in the past four decades do not suggest basic defects in the American system."

Obviously one does not find defects in the American system of health services by looking at the advances in health which have occurred either as the result of developments wholly apart from that system or despite its defects. When, however, one considers the advances in health which could have been made but which were not made, and when one inquires into the reasons why they were not made, then one cannot but conclude that there is "a basic defect in the American system." This defect is in the method of paying for medical care. Payment for medical care should be budgetable, i. e., the insurance principle should be applied. The very advances in medical science and in length of life which have taken place during the past four decades have increased, not diminished, the financial burdens of medical care and the need of budgeting its costs.

A third major conclusion (No. 8) rests on two sentences which reflect a point of view pervading the entire Brookings report. They are as follows:

"The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy" (p. 68).

The evidence is clear that not just "some" of the American people, but the majority of them, are not able to pay for adequate medical care when payment must be made on the usual fee-for-service basis. The remedy however is not charity. Most Americans will not accept charity. The remedy is health insurance. Through the principle of insurance people of all income groups, except the wholly indigent, can prepay their medical costs and receive care when they are sick as a right and not a charity.

How shall "public funds or philanthropy" provide for those who cannot pay for medical care? To answer this question, the report is led into discussion of the "means test" (pp. 61–65). The aim is to justify the means test, as the method for determining who are unable to pay for medical care and, therefore, who shall be entitled to receive free care from public funds. The free care might be supplied directly, or through a health insurance plan to which public funds have contributed in behalf of these persons.

The report admits that the means test has an "evil reputation" among many persons and that it often used to be administered with harshness. Nowadays, however, says the report (p. 63), those who administer the means test, "are frequently sympathetic and gentle—some think too sympathetic and gentle."

"In the old days", the report continues, "the means test represented one of the few instances in which government pried into the personal affairs of the individual and the family. It represented a violation of the right of privacy" (p 63). Nowadays, however, government extends prying hands in other ways. Present income and inheritance taxes and various business taxes, it is explained, require persons to devote annually "hours of their time to making out reports for the Government regarding their affairs" (p. 63). This, declares the report, is a form of means test.

Here again the authors do not consider in the least the human meaning of the matter they are discussing. A means test applied to a person to determine whether he shall receive public relief in the way of food, clothing, or medical care, not only exposes him to personal investigation but to public knowledge that he is an object of charity. The filling out of an income-tax form—no matter how many hours of time are spent on making it—violates neither the right of privacy, nor the self-respect of the individual.

The report then goes further. Is the elimination of a means test a good thing? Very questionably, for—says the report, "Attempting to spare the individual the humiliation of a means test and of receiving services which have not been earned by his own efforts or those of persons responsible for him may weaken the sense of responsibility of many persons to whom life is at best a struggle." It is doubtful—so, it runs on—whether "the well-to-do should bear the cost of freeing the poorer people from the humiliation of the means test."

Comment on these statements is unnecessary to any reader who believes in the maintenance of human dignity as the basis of a democratic way of life in America. For many years, the trend of American thinking and of national and State legislation has been away from the means test, particularly in application to medical care. Furthermore the Brookings views on this matter are in direct contradiction to the conclusions reached by both lay and professional groups as to the principles through which medical care should be financed.

Thus, at the National Health Assembly, a few weeks ago, the following statement was agreed upon by representatives of the American Medical Association and of 17 national organizations, including labor, farm, professional, and other groups having at least 15,000,000 members:

"The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services, and avoid the indignities of a means test."

The remaining conclusions of the report (Nos. 9 to 15) summarize the attack upon compulsory health insurance which has already been discussed. These conclusions, it has been shown, combine misunderstanding of the subject and misrepresentation of the actual legislation proposed.

It has also been demonstrated that most of the problems and deficiencies alleged against compulsory health insurance must be solved by voluntary health insurance plans also.

BROOKINGS' RECOMMENDATIONS

The practical proposals offered by the report are confusing. Three formal recommendations are stated on pages 70–71, but several others, perhaps more important, appear elsewhere.

In view of the many pages filled with criticism of compulsory health insurance, it is surprising that the first formal recommendation proposes that "the National Government would be wise to leave to the individual States the question of whether compulsory health insurance is to be adopted" (p. 70). This seems to be acceptance in principle or at least toleration. However, the bulk of the report is so clearly adverse to compulsory health insurance that even toleration of the idea, on a State basis, need not be taken very seriously. except as indicating lack of precise thinking.

The main point of the first recommendation is for "experimentation" with varied methods of paying for medical care.

The second and third recommendations merely urge the National Government and many of the State governments to confine their efforts for the time being, to public health, education, aid in providing hospitals, and care for "the indigent and the medically indigent." Health education campaigns for adults would be left to voluntary organizations.

The section on recommendations then goes on to quote from the report of the Committee on the Costs of Medical Care, made in 1932 and endorsing voluntary health insurance.

Experience since 1932, the Brookings report declares, has "demonstrated the wisdom" (p. 72) of this proposal. Experience since 1932 has also, it should be added, demonstrated its inadequacy. In 16 years. less than one-third of the American people have been supplied with any kind of health insurance. Less than 4,000,000 persons—or under 3 percent of the population—have been supplied by voluntary insurance plans with comprehensive medical care. A possible total of 40,000,000 persons (the exact number is uncertain because of unknown duplications) have voluntary "health insurance," offering in many cases only cash reimbursement for part or all of their hospital bill. Some are guaranteed hospital service and surgical services during hospitalized illness only. The recent trend is in the direction of restricting rather than expanding benefits.

The use of tax funds to care for needy persons, screened by a means test is certainly one of the basic recommendations of the Brookings report, although it is only lightly referred to on pages 70–71. Voluntary health insurance supplemented by poor-man's medicine here seems to emerge as the Brookings program.

CONCLUSION

Thus at first glance and viewed as a whole, it seems that the Brookings report recommends a policy of encouraging voluntary health insurance plans, supplemented by a system of poor-man's medicine. On close inspection of the report, however, it becomes evident that the authors themselves doubt the sufficiency of voluntary health insurance. The authors continually insist that "most consumer units" would have the capacity to pay for voluntary health insurance if "they would give medical care a high priority with a preference over expenditures for automobiles, alcoholic liquors, tobacco, recreation, and savings" (p. 185). At once, however, the authors go on to question the willingness of many consumer units to give this priority. Then, on page 187 of the report, we learn that health insurance may have to be made compulsory after all. A comparison is made with automobile accident insurance which a few States have made compulsory on all car owners. "The compulsory insurance is, however, with voluntary companies of the insured's own choice, provided the voluntary companies comply with State laws governing that type of insurance business" (p. 187).

This idea is then applied to health insurance. The State or National Government, says the report (p. 187), could force people to give a high priority "to the costs of medical care in family financing." It (the Government) "can require that an individual and those dependent upon him shall be insured against the costs of medical care in a voluntary organization of his own choice." The voluntary insurance plan would have to be approved by a State or National agency; the individual might be given a choice between taking out such health insurance or he might have to "deposit in trust with an approved agency resources sufficient to meet maximum probable costs of medical care" (p. 187). Faced with this choice, says the report, all but a few individuals would accept the first alternative of joining a "voluntary" insurance plan.

The authors then list five "advantages" of this proposal. It is suggested, for example, that "high administrative costs" would thus not fall upon the National Government. It is true, the costs would not fall on Government but would fall on the people who had to join insurance plans and the costs would be very high indeed under such a system.

Under this Brookings proposal, the Government would of course retain responsibility for the "indigent and medically indigent" and "possibly" for people who are "bad risks," which the voluntary plans would not enroll. The number of people in such a group is not estimated by the authors. This omission was fortunate from their point of view, because the number of such persons might be inconveniently large. Certainly the cost of service to a group of "bad risks" plus the "indigent and medically indigent" would be extremely high.

Imagine a system under which everyone would be compelled to insure in at least one voluntary plan operating in his locality, or maybe in two or more plans in order to get all the medical service he needed. Some plans would be run by commercial companies, some by nonprofit organizations, some under labor-management agreements, some as cooperatives. Some would provide hospital care only, some much more. The State or the National Government would have not only to assure the fiscal soundness of the plans but also to see that the medical benefits offered were up to at least a minimum standard of quality. Else how could compulsion be justified, forcing people to put their money into a private organization over which they would ordinarily have no control?

Medical-care insurance is so much more complex and so much more vital to human beings than automobile insurance, that the kind of compulsory system which works in Massachusetts for automobile owners provides no argument whatever for a corresponding system of health insurance. Actually the proposal of these authors would force Government into ultimate detailed regulation of voluntary plans. The very varieties of geographical and medical coverage would necessitate a high degree of public intervention in order to prevent abuse and to insure minimum standards of service.

In summary, the authors of the Brookings report first denounce compulsion in principle, then finally accept it, but the method they propose for its application reeks with danger. The plan of compulsory health insurance which they recommend would not be simple, but complex and confusing. It would not be economical, but would be very costly. It could not deliver adequate medical service without an indidious degree of public regulation. It would place the benefits of public taxing power in private hands.

SUMMARY OF MAIN POINTS

The main findings of this review of the Brookings report may be briefly stated.

1. Compulsory health insurance is condemned without any analysis of the actual operation of the various forms of health insurance in the United States and other countries; and without any recognition of the fact that most of the difficulties alleged against compulsory health insurance are faced and must be solved by voluntary plans also.

2. The central problem of unpredictable sickness costs is never met squarely. In consequence, the authors are led to inaccurate conclusions regarding the ability of people to pay for medical care.

3. The report's major recommendation, i. e., reliance on voluntary health insurance is unsupported by any explanation how voluntary insurance plans are to overcome their difficulties in enrolling most of the population. That the authors themselves doubt the possibility of this is evidenced by their untenable proposal that the Government compel most people to join voluntary plans.

4. Although the authors consider it would be necessary to supplement voluntary health insurance by extensive tax-supported medical care for persons who pass a means test, they never estimate the size of the tax burdens that would result, nor the administrative cost of means tests, nor the political and professional implications of such a program of State medicine. The authors discuss the means test in terms that are neither valid nor decently human.

5. The parade of mortality, morbidity, and other statistics which fills a large part of the report leads to some conclusions that the technically correct but few that are important to the central issue of health insurance. The authors have wasted much effort in studying pros and cons of health needs at a time when—as at the recent National Health Assembly—all professional and lay groups are in accord as to the need for the widespread extension of health insurance in one form or another. The problem now is how to move forward. If the authors had really studied the administration of health insurance and furnished guidance instead of dogma, their report would have been infinitely more useful.

NATIONAL HEALTH PROGRAM

WEDNESDAY, MAY 26, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee hearing room, Capitol Building, Senator Forrest C. Donnell presiding.

Present: Senator Donnell (presiding).

Senator Donnell. The committee will be in order. Dr. Shearon, you may proceed.

STATEMENT OF MARJORIE SHEARON, PH. D.—Resumed

Dr. Shearon. Senator Donnell, yesterday you introduced into the hearing an editorial, and since it is in many respects quite in opposition to the statement I have been making, I think I would like to go back a little bit and point out one or two of the statements in there, especially in view of the fact that——

Senator Donnell. That was an editorial of the Journal of the American Medical Association?

Dr. Shearon. Yes. And I suppose I said "May 3," but the date is May 8th, an editorial of May 8th concerning the National Health Assembly, an editorial appearing in the Journal of the American Medical Association. I am in entire accord with the part that was read, in which it was pointed out that President Truman had come out in favor of compulsory health insurance, and although it does not mention it here in the editorial, Oscar Ewing himself, head of the Federal Security Agency, stated that he was definitely in favor of compulsory insurance. This was at a meeting of the assembly, that was supposed not to be engaged in lobbying activities, and was a private corporation which was raising funds as an organization not engaged in lobbying. In this editorial it says, and I quote:

> Previous conferences have been suspect of having been propaganda in behalf of certain proposals leading to legislation as their prime motivation. If that was the original intent of the National Health Assembly in 1948—and it seemed to be such when the proposed assembly, its financial supporters and executive committee were announced a few months ago, the subsequent developments and final action taken have resolved the doubt and anxiety.

That is the end of that quotation. I think that the person who wrote the editorial was not very well informed about what was going on behind the scenes. Perhaps he was not present a good deal of the time, or he had a great many other things to do. At any rate, it does not quite describe the things that took place. I think it has very clearly been shown that there was lobbying going on, and that it was not wholly a National Health Assembly but a political meeting for political purposes, and so timed in many respects.

I want to continue from where I was before, quoting from the editorial. It says further:

> For this, credit should be assigned, perhaps, to Mr. Ewing and his associates, notably Dr. Howard Kline, who evolved some of the original executive committee of 24 members, with only one physician, a final committee aggregating 39, with official representatives for the American Hospital Association, the American Dental Association, the Conference of State and Provincial Health Officers, the American Medical Association, and similar bodies.

I read that particularly to call attention to the fact that he gives credit to Mr. Ewing and to Dr. Howard Kline. Dr. Kline is a Ph. D. who, during the war, was on the staff of Mr. George Perrott of the Public Health Service, in the Division which has been working for a long time for nationalization of medicine.

Senator DONNELL. Dr. Kline is not a physician?

Dr. SHEARON. No, he is Ph. D. He then went over to the American Public Health Association, which is now paying his salary, and that association has a platform which was rigged by Federal officials in favor of the Wagner-Murray-Dingell bill. We have a good deal of testimony about the way in which that platform was put over in 1944, not representing the opinions, or not having been referred to, the membership of the organization, but having been put through in a great rush by a small, organized minority in which Federal officials who were interested in this legislation and who had written it, took the leading part. But Mr. Kline is now employed by that organization. He is not paid by the Federal Government but is now occupying Federal space—and I refer here to this telephone book of the Federal Security Agency. I have the page number here and the telephone numbers for Howard Kline and Cornelius A. Wood.

Senator DONNELL. Would you mind putting those telephone numbers in the record? What telephone book is it?

Dr. SHEARON. This is the April 1948, telephone book for the number Executive 6300, which is the Federal Security Agency number, and also Sterling 7600, which is the number of the Securities and Exchange Commission. On page 23 appears the name of Howard M. Kline, room 4611 in the Federal Security Building, telephone 3397. His name appears here on a page with other Federal officials, and you could not tell it if you did not know that he was not a Federal official. Nor could you obtain any information from the Civil Service Commission about him, nor from Mr. Ewing.

On page 37 appears the name of Abe Savage, room 4605, Federal Security Building, telephone number 3110. He is one of the incorporators of the National Health Assembly, Inc. On page 46 appears the name of Cornelius A. Wood, Jr., room 4611, Federal Security Building, telephone number 2030.

These three persons are not on the Federal pay roll, unless they have come on in the last few days.

Senator DONNELL. The Federal Security Building is a United States Government building?

Dr. SHEARON. That is right.

Senator DONNELL. Occupied by the Federal Security Agency?

Dr. Shearon. That is correct. This editorial goes on to speak about the representation in the National Health Assembly, Inc., and it states that there was broad representation from all types of health organizations, and that there was not—it says:

"These sections"—

that is, the 14 sections that the Assembly was divided into—

> held four or more meetings in which opportunity to speak was given to any of those who wished to be heard on the subject of their own experience or their criticisms of the opinions and experience of others.

That statement is inaccurate, as I explained yesterday. People were not allowed to speak in regard to their experience and their knowledge. The only persons who could speak were invited delegates, and they had been invited by the Government, and in a great many instances they had been invited for obvious reasons, because of their past connection with the compulsory health insurance movement.

Now, I spoke of the executive committee as originally appointed. It consisted of 24 persons, and these were purported to be outstanding persons in the field of health, interested in or having knowledge in the field of health, and I quote what Oscar Ewing said at the time he put out this advance release—which, by the way, came from the Federal Security Agency. It looks like any other release put out by them. It was put out on February 15, 2 days before their articles of incorporation were filed.

Senator Donnell. Does the heading in any way refer to the Federal Security Agency?

Dr. Shearon. Yes, sir. It says "Federal Security Agency, Washington 25, D. C."

At the top left-hand corner, so many of their releases have the name "Franklin," and I assume that refers to their publicity director, Mrs. Zilpha Franklin. After the "Franklin" in the left-hand corner at the top of the page it says: "C. P. F. 300. Extension 3178." Yesterday I checked the telephone book of the Federal Security Agency, and I find that the telephone extension given here, 3178, is the extension of Mrs. Zilpha C. Franklin, who is in room 5548, Federal Security Building. And this is headed also on the right-hand side "F. S. A. 333." So I think there could be little doubt that it is an official Federal Security Agency release. It is therefore, presumably, prepared by and with the help of the usual Government staff for publicity releases, and presumably sent out through the usual channels, which involve expenditure of Federal funds.

In this release Mr. Ewing says:

> I consider the request of the President one of the most important assignments ever given in peacetime to a Federal agency, and the projected National Health Assembly can be of tremendous value in helping the Federal Security Agency in carrying it out.

Now, among these first 24 persons who were selected as the top policy committee for this national assembly, appeared the name of Miss Frieda B. Hennock, New York City. The name has not registered with me in any way, although I have been in this work, in this field, a long time. I did not have a chance to check on it, but when Mr. Kingsley testified before the Appropriations Committee he read her name and stated that she was a Wall Street lawyer.

Senator Donnell. Is this the person who has just been appointed on the Federal Communications Commission?

Dr. SHEARON. Correct. I wish to introduce in the record this clipping at this time, and to point out particularly that it states she has been an important figure in the Democratic organization in New York. It does not say that she ever had anything to do with the health field. It does not imply that in any way.

Senator DONNELL. This clipping will be incorporated in full in the record. I notice it says Miss Hennock has been a lawyer in New York for more than 20 years, specializing in corporation practice.

> Friends here said she is close to the Democratic organization in her home State and was active in Mayor O'Dwyer's city campaign.

Also it says:

> She has never tried a case before the Communications Commission, but has been identified with court actions in the radio field in New York.

You never heard of her being in any way connected with the study of health or insurance matters of that kind?

(The article referred to follows:)

[Washington Post, May 25, 1948]

PRESIDENT NOMINATES WOMAN TO SERVE AS MEMBER OF FCC

President Truman yesterday proposed to give the Federal Communications its first woman member.

The President nominated Miss Frieda B. Hennock, New York City attorney. Her name was sent to the Senate for a 7-year Federal Communications Commission membership in succession to Commissioner Clifford J. Durr.

Durr's term expires June 30. A Franklin D. Roosevelt appointee, Durr has notified Mr. Truman that he does not wish reappointment. He has recently been an outspoken critic of administration policy in the loyalty check being made among Federal employes.

Mrs. Durr announced several weeks ago that she would take an active part in the Henry Wallace campaign for the Presidency.

Miss Hennock has been a lawyer in New York for more than 20 years, specializing in corporation practice. She has never tried a case before the Communications Commission, but has been identified with court actions in the radio field in New York.

Friends here said she is close to the Democratic organization in her home State and was active in Mayor O'Dwyer's city campaign.

As a Democrat, her confirmation by the Senate would continue the even balance between the major parties on the Federal Communications Commission, which now comprises three Democrats, three Republicans and one independent.

Now in her forties, Miss Hennock was born in Poland, where her American father was in real estate and banking. She came to this country at the age of 6 and was graduated from the Brooklyn Law School.

Since 1941 she has been a member of the firm of Choate, Mitchell & Ely, New York corporation lawyers. From 1935 to 1938 she was assistant counsel to the New York State Mortgage Commission.

Dr. SHEARON. No. And it gives her background in the second column there, the bottom of the second column. I doubt if she herself would make any claim to having been expert in this field or having anything to offer that would be of help in establishing health and medical policies. There may have been political policies that she would have been helpful with.

To come back again to something of the analysis—I have not written it up yet—of this executive committee, the way in which it was weighted, the persons who had had a long record of having worked for the nationalization of medicine. I should also point out that it is heavily weighted with persons in New York. In other words, it is not at all a representative committee, and even after it was edited a little bit, a great deal of protest went up over the selection of the 24—it still is a heavily weighted committee.

We were interrupted yesterday when we had to close, when I was at the top of page 22 of my testimony. I was in the middle of a paragraph in which I was discussing the capitation system, and a few of its implications. I had been discussing the fact that if they had the capitation system the patient could not wait until he was ill—the person could not wait until he was ill, to select a physician, but would have to come in at the beginning in order to assure the payment of the income of the physician on whose list he appeared. If the capitation system is in effect he will be compelled to select his doctor shortly after the system becomes operative, because the insurance doctors will have to have their lists of patients or they will not be paid by the Government. It is to be remembered that after the capitation system becomes operative, every insured person in the community must sign up with some doctor, for insured persons under such a system become simply pathological entities worth so much per head per year to the doctor on whose list they appear. If an insured person fails to sign up with a doctor he will be notified, say, within 3 months, that he has has been assigned to Dr. X or Dr. Y, whose lists were not full.

Senator Donnell. In your mimeographed statement, doctor, I notice you quote the words "pathological entities". Who is the person from whom you quote?

Dr. Shearon. That is a statement made by a doctor in New Zealand, where they have this sort of situation. That was Dr. Jamieson. That, I think, is an extremely important point, that if you refuse to get in on a doctor's list, and the capitation system is in effect, then the Government will assign you to a doctor. You are told you are recalcitrant; you must get in, and it is important for the insurance system that you do get in, and therefore you would be assigned. That, of course, would come out largely in the rules and regulations, although it has been indicated in the proposed legislation that such assignments would take place.

Under the proposed capitation system the doctors would be paid their small annual fee whether they performed any services or not. In other words, each insurance doctor would be expected to assume the unlimited risk of the care of 1,000 to 1,250 patients, to give them all the services they might seek and that the Government demanded. This they would be expected to do for a limited, fixed fee of $5 or $6, or some other small amount per head per year. In New Zealand the capitation rate is $1.50 a year; in Great Britain it is $2.25.

It is obvious, of course, that if the Government is short of funds it can change the capitation rate. That has been done in Great Britain when they were short of funds. Consequently, the doctor, in order to make a living, is bound to take on more patients up to the limit he is allowed by law. In Great Britain that limit is 2,500. It is quite likely we might change the limit in this country if there were pressure on funds and the doctors complained of the small capitation fee. Then they might say to the doctor: "Well, temporarily, you can take more patients in order to make more money."

Such fluctuations and such additions of patients to crowded lists, obviously make for poor medical care, and this is one of the reasons why the medical profession is very strongly opposed to this method of payment. Some persons claim that the medical profession has ulterior motives in its opposition. I do not doubt that some physicians do have ulterior motives. In any large profession there are certain persons whose motives are not the best, but by and large, I think the medical profession has the best of reasons for opposing such a method of payment, because it would directly affect the medical care of the individual.

I am quite certain that the members of this subcommittee will readily see that the capitation method of payment is wholly unfair. It is argued that medical services being too expensive to be paid for by the persons receiving the services, the burden is to be dumped on the doctors who are ordered to assume a major portion of the expense. They are told they must give all patients all the care they need for a flat sum of $5 or $6 a year. They would be put completely at the mercy of neurotics and of chronic patients whose large demands would not, however, entitle a doctor to receive any extra pay. I do not know of any other case in which services are performed either by trades or by professions in which there is no relation between the amount of pay received and the service performed. Organized labor would not agree to any such arrangement of payment for its own services. Yet this is what would be done to the medical, dental, and related professions under a capitation system. This is what is meant by regimentation of patients and practitioners. I cannot emphasize that point too strongly, because it is a ridiculous situation where the Government promises the services of a professional person and says that a patient who comes to that professional person may have all the services he demands, and yet the pay is to remain fixed. That, I think, is one of the major defects in the capitation system.

That this capitation method of payment is unfair has been recognized even by the International Labor Organization itself, which points out that "the capitation fee system suffers from the fundamental defect that doctors receive an income inversely proportionate to the amount of work involved or given." That quotation is found on page 87 of this report that I mentioned yesterday by the ILO, printed in 1944. It is almost the Bible of the world plan for nationalization of medicine, and I think it is significant that an organization like the ILO, which has been working for years for the extension of social insurance all over the world, should itself be honest enough to admit that the capitation system suffers from this fundamental defect, yet this system is being proposed for the United States. It is in the Wagner-Murray-Dingell bill as one of the methods of payment, and it is the method, as I pointed out before, that was given the most prominence in the book on Medical Care Insurance to which I referred yesterday.

To get around this inequity, the ILO proposes a basic salary augmented by capitation fees, or, alternatively, a full-time salary. I may say, these alternatives are given in the Wagner-Murray-Dingell bill.

In 1944 the ILO stated, page 89 of this same volume:

> A salary system is actually in force in Chile, Peru, Costa Rica, and Russia, and its introduction is proposed in the plans of the South African Medical Association, the Parliamentary Committee on Social Security and the National Health and Medical Research Council of Australia, and the Labour Party and the Socialist Medical Association of Great Britain.

Perhaps you would like to have a copy of this [handing a paper to Senator Donnell].

Senator DONNELL. Yes; I would.

Dr. SHEARON. The Government planners have it clearly in mind to lead this country straight into the Russian form of medicine. Carl Malmberg so states in his recent book, which is just off the press—it was when I wrote this testimony in January. This book is entitled, "140,000,000 Patients," by Carl Malmberg, who was formerly a ghost writer at the Public Health Service on the staff of Dr. Mountin, who has in recent years become a protagonist of compulsory health insurance, after getting instructions from officials of the Social Security Administration. Carl Malmberg was loaned to the Pepper subcommittee of this committee, worked with it for some time, and then went to the Democratic National Committee. I understand he is no longer there. But he put out the book which has been cited a number of times in these hearings, and about which I shall have more to say later in regard to some of the utterly inaccurate interpretations of vital statistics.

Mr. Malmberg says on page 230 of this book:

> Neither would compulsory health insurance necessarily be the final answer to our health problems. It is quite possible that the people of this country might some day decide to pay for all or most medical services out of general tax revenues just as they pay for most educational services today.

I repeat the words "out of general tax revenues." Continuing—

> There would be many advantages in such a method. Great Britain has already taken a long step in that direction with enactment of its National Health Service Act. Sweden is moving in the same direction. In the next decade, several countries which now have compulsory health insurance will probably do likewise.

In other words, as Mr. Malmberg pointed out, they start with a compulsory health-insurance scheme which is financed through earmarked taxes on employee and employer, with a subsidy from general revenue taxes, and, they finally end up with an entirely tax-supported program. That is what they have in Russia now. That has been the history in Russia, where in 1911, at the same time Great Britain put through its health insurance Russia did the same thing, and then eventually moved over into a full-time salaried service. This, I suppose, is another reason why, not only the medical profession but a great many persons outside the profession are suspicious of a so-called health-insurance scheme, because it is not so much what the start is as what they are going to end up with eventually.

What choices would remain to us, then, under a Government scheme of medical care, if the International Labor Organization condemns the capitation method of payment as unfair, and protagonists for compulsory sickness insurance insist that the fee-for-service method is administratively unworkable? Both of these statements are true. We are left, then, with a salaried Government service as the one preferred by the ILO, Russia, Carl Malmberg, and certain Federal officials. After all, we have only a limited number of ways in which we can pay people. We can pay doctors on a capitation method, or a pure salary, or on the fee-for-service, on which basis they are now paid, or you could make up a combination of those methods. I do not think there are any other ways.

If you throw out the capitation method as unfair, and the fee-for-service basis as unworkable, you are left with the salaried service, which is, of course, the method that some people advocate. They have advocated it in Russia. In fact, if the first two methods are unsatisfactory under a Government plan, one comes to the conclusion that a salaried service is inevitable for accomplishing the national system of Government medical care. But President Truman has stated, correctly, that "the American people want no such system." I might add, if they don't want it, why does President Truman propose it?

In the light of these facts it would appear that the Federal Security officials have brought the President face to face with an insoluble dilemma.

Senator DONNELL. Doctor, has the President proposed the salaried service.

Dr. SHEARON. No, he has not.

Senator DONNELL. Is that what he is talking about here, in that language?

Dr. SHEARON. No; he has proposed a compulsory insurance scheme which, we may say, is combined with a partial salaried service. In other words, there would be quite a number of services which, from the start, would be on a salary basis, but insurance would be the primary thing.

Now, it has been pointed out by persons on both sides of the fence that such an insurance scheme leads to a salaried service.

Senator DONNELL. What system is this that the President refers to, when he says that America wants no such system?

Dr. SHEARON. He was referring there to—I have a copy of it—he was referring to so-called state medicine. Some people like to make a distinction between what is called state medicine and health insurance. State medicine is very definitely defined as medicine which is delivered by persons who are on a salary. On the other hand, there are implications in state medicine that the main thing is Government control of the doctor and Government control of the patient. Therefore, it doesn't make too much difference whether he is on a stated salary or whether he gets a sum that is fixed by the Government, as the capitation method, or whether he gets a fee that is determined by the Government. It is all Government controlled. Persons would feel that that would be state medicine and that you cannot split hairs over the portion the physician might get as partly capitation pay and partly fee-for-services. It is the control: that is the essential thing in state medicine, the control of the physician himself, the control of the method of payment, and the control of everything that he does.

Senator DONNELL. Then will you return to the statement by the President?

Dr. SHEARON. I cannot put my finger on it right away, but in one of his speeches—I am not sure whether it was the last one—this came out in a hearing in which he stated that the people of the United States want nothing of state medicine. I could put that in very easily.

Senator DONNELL. Let the record show at this point that Dr. Shearon will provide that quotation and have it inserted in the record here.

(The quotation to be supplied appears 4 paragraphs hereafter.)

Dr. SHEARON. I might say that President Truman, like many other persons in this field, has been misinformed about the legislation that he is sponsoring, and that no one has sat down and actually explained to him what the legislation would do. I am not inclined to charge bad faith on his part or on the part of any of the Senators who are sponsoring S. 1320, or any of the bills of that type. I think they have been misinformed by persons who themselves are very well informed.

Continuing my testimony, I say it would appear that the Federal Security officials brought the President face to face with an insoluble dilemma, for it is quite evident that they have led him to endorse a national health program which would lead to a system of state medicine with a salaried medical service, no freedom of choice, and the abolition of the private practice of medicine. Yet the President recognizes that the American people do not want such a system.

It is futile for the Federal Security officials to say: "This would not be socialized medicine." From the very beginning it would be at least partly socialized or state medicine under Federal control, and would constitute an immediate stepping-stone to a salaried service. That is the plan. That is the experience elsewhere. I have the statement right here. The President was, therefore, in error when he stated in his message on a national health program, November 19, 1945:

> I repeat—what I am recommending is not socialized medicine.
>
> Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

That was the speech I had in mind.

Senator Donnell. That is what you had in mind?

Dr. Shearon. Yes. At that time, November 19, 1945, you will recall that he introduced S. 1606, on which we had hearings in 1946.

It is unfortunate that the officials who prepared that statement for the President sought to mislead him, the Congress, and the public, by writing something they knew to be untrue.

I think it is extremely important for us to realize that the Congress and the public have not been getting the facts about what this legislation would do. The doctors right from the start would be, to all intents and purposes, employees of the Government. They would not be free agents any longer if they signed the Government contract. They would be paid in one of several ways, but they would still be under Federal control. They would not be free citizens any longer, and to make a statement of this sort, that this is not socialized medicine, I think is extremely misleading. I do realize that at present socialized medicine is not clearly understood. I do not like the term myself. Mr. Falk stated he does not like it. I think that is about the only thing on which we agree. I don't like it either. It is a misleading term, but it has been used a very great deal. I use it myself. I have used it in some pamphlets I have put out, very largely because it is rather generally understood by the public. I prefer the term "nationalization of medicine," because that makes very clear what you intend to do. You intend to bring medicine under the control of the Federal Government. That is a perfectly clear concept. Take "nationalization" of railroads and of communications and of banks and of coal—we know what that means, so that is the term that I ordinarily use.

It must be increasingly clear that the requests for these revolutionary changes are coming not from the people but from a small group of interested Federal officials. I cannot recall that any private citizens or the representatives of any considerable part of the population have appeared at these hearings urging the Congress to abandon the present form of medical practice in this country. Nor have they urged that the panel system or a salaried Government service be adopted in lieu of the present system. I will return to this matter later, but at this point I wish simply to say that neither the Congress nor the public has yet had the facts about the form of medical practice that is contemplated under S. 1320 or about other matters of the greatest importance, namely, the costs, methods of administration, and the experience in other countries.

I would like to refer at this time to a little pamphlet that has come up many times in the hearings, and I have a few things to say about it. It is entitled "Principles of a Nation-wide Health Program—Report of the Health Program Conference." It was published in November 1944 by the Committee on Research in Medical Economics. That report was signed by a group of Federal officials, and it has since that time been used as expressing the views of health experts with regard to principles of a Nation-wide health program. It was printed in November 1944, just before the introduction of the two Wagner-Murray-Dingell bills in 1945. In other words, it was preparing the way, spading the ground. It was influencing the opinion of the public in the way in which it was designed to go.

These Federal officials say they were not lobbying. I do not know that we have an exact definition of lobbying, but were they or were they not trying to influence Congress with regard to legislation? We had a bill then pending—that was 1943—the Wagner-Murray-Dingell bill, and Federal officials in the fall of 1944 were writing the bill that when it was introduced was S. 1050 in 1945. So that we had continuing bills before Congress in this field, and at this time these Federal officials—I will mention them by name—Dean A. Clark, M. D., United States Public Health Service; I. S. Falk, Social Security Board; Frederick D. Mott, M. D., Farm Security Administration; George St. J. Perrott, United States Public Health Service; Kenneth E. Pohlmann, Farm Security Administration; Barkev S. Sanders of the Social Security Board, and William Haber, who is on the faculty at Ann Arbor but on loan to the Federal Government. These officials in the Federal Government all signed this report on the Principles of a Nation-Wide Health Program, and then by a curious coincidence when the legislation was written and came out as S. 1050, it incorporated these principles. Whether that is lobbying I do not know, but it strikes me that it is pretty near it.

Then the company with these Federal officials were such well-known figures as Ernst P. Boas, chairman of the Psysicians' Forum; Allan M. Butler, member of that forum; Michael M. Davis, chairman of the executive committee of the Committee for the Nation's Health; Channing Frothingham, chairman of the Committee for the Nation's Health; Franz Goldmann, formerly of Yale, now of Harvard, and before that from Berlin, Germany, a member of both the Physicians' Forum and the Committee for the Nation's Health; Gerald Morgan, friend of the late President Roosevelt, who is a member of the Committee for the Nation's Health; John P. Peters, a member of the Physicians' Forum; Kingsley Roberts, member of the Committee for the Nation's Health; Edwin Witte, the same; C. E. Winslow, same; J. Raymond Walsh. These I know are practically all members of the Committee for the Nation's Health or of the Physicians' Forum, and this group worked with the Federal officials and signed this report.

Among the things that they subscribe to —I will read just two of them—

> A national health program should therefore include in coverage all or most of the population. Finances—The chief support of a Nation-wide system of medical care, should be contributory insurance required by law, with the amount of payment from employees and employers and self-employed persons related to the means of the contributors, and combined with support from general taxation.

There is the pattern of national compulsory health insurance. The "contributory system"—they have used that over and over again. They do not say here it is compulsory. They say "contributory insurance," and that is why I took exception to the use of that term in the report as it came out of the medical care section of the National Health Assembly, because contributory insurance has long meant this pattern of insurance, including taxation of employees and employers and the self-employed, with the help of general taxation.

They also say:

> We agree that the recent statement of the International Labor Office that medical care should be—

quoting from the ILO—

> provided without qualifying conditions as to payment of contributions or taxes, and without a means test.

That is the end of the quotation from the ILO. This is what our Federal officials put down as the principles that they were working on. They come then to the writing of the Wagner-Murray-Dingell bill, which endorses their principles, and quote from the International Labor Organization, which it is well known is a socialist-dominated organization headed for the first 15 years of its history, 1919–34, by the leading French socialist in Europe, Albert Thomas. I submit that as evidence of the fact that these officials were lobbying.

The establishment of a system of national compulsory medical care insurance for the entire population would be an undertaking of colossal proportions. In no other country in the world has any similar scheme, of such proportions, been proposed save in Russia, which has a complete salaried service under a peculiar and meager form of national compulsory insurance operated by the Communist state without any direct payment of taxes by the people.

It is rather fortunate for us that there is available an illustration, on a small scale, of what might happen were we to try in this country such a scheme as is proposed in S. 1320. In 1938 New Zealand enacted a comprehensive social security law similar to the one that has been proposed for the United States. I have described the experience in that country in detail in a brochure, New Zealand's Free Medical Benefits, which I submit for the record. I purposely have not attempted to go into that story at this point, but I think it is of the utmost importance that a great deal of thought be given to what has happened in New Zealand, where the same sort of program was instituted, and the Labor Party passed a law in 1938, a social security law——

Senator DONNELL. Doctor, are you filing this or do you want it incorporated in the record?

Dr. SHEARON. I would like to have it incorporated in toto.

Senator DONNELL. It will be so incorporated at this point in your testimony.

(The document referred to entitled, "New Zealand's Free Medical Benefits," is as follows:)

SOCIALIZED MEDICINE

Physicians and patients enchained by unwarranted governmental regulative interference

[Vol. I. No. 5]

NEW ZEALAND'S FREE MEDICAL BENEFITS

(By Marjorie Shearon, the Shearon Medical Legislative Service, Washington, D. C.)

THE AUTHOR

Marjorie Shearon, Ph. D., scientist, lecturer, and legislative consultant, was formerly research analyst to the Senate Minority Conference (1945–46) and health consultant to the Senate Committee on Labor and Public Welfare (1947). Prior to that she spent nearly a decade in the executive branch of the Federal Government, 5 years with the Social Security Administration, and 4½ years with the United States Public Health Service.

Prior to her 15 years of public service—Federal, State, and local—she was engaged in scientific research in the biological sciences, her original contributions to science being in the field of evolution. A fellow of the American Association of University Women, past fellow of several national scientific societies, she is a member of Phi Beta Kappa and Sigma Xi.

She is the author of numerous scientific articles and of: Economic Status of the Aged; Health and Disability Legislation in the States: 1939; Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interference; Federal Propaganda for the Welfare State; Paradise Unlimited—the Menace of the Police State; and Bureaucratic Control of Medicine. She is author of American Medicine and the Political Scene, a weekly analytical news release which she publishes as director of the Shearon Medical Legislative Service.

(Copyright by the Shearon Medical Legislative Service, January 1948.)

VEST-POCKET EDITION OF NATIONAL COMPULSION

New Zealand's experiment in nationalized medicine is often cited as a model which might be followed in the United States. The free medical benefits of that country are similar to those which have been proposed for the United States in the successive Wagner-Murray-Dingell bills. Furthermore the New Zealand experiment in comprehensive national compulsory social security parallels our own, the New Zealand Social Security Act having been passed in 1938. The social-security laws and programs of that country are the result of prolonged study and represent the last word on the subject.

Particular importance attaches to the New Zealand experiment because it serves as a vest-pocket edition for all other countries to study. New Zealand is a small country about the size of Colorado, with a population (1.7 million) about equal to that of Colorado or Detroit. The population is homogeneous, except for the Maoris, who constitute 5.3 percent of the total. There are no large industrial centers. The people, engaging largely in pastoral pursuits, have ready access to farm and dairy products of high nutritional value. New Zealand, as a sparsely populated, comparatively young country, has in the past been receptive to a certain amount of socialization. Hospitals, for instance, are mostly public institutions, with board members elected by popular vote.

In such a country, if anywhere, a program of national compulsory social security for the entire population might be expected to succeed. If the experiment had succeeded in New Zealand, one would not be justified in concluding it would succeed in the United States, for the two countries are totally different in industrial development, composition of population, climate, cultural patterns, geographic conditions, and the like. However, if the experiment has failed in New Zealand, under ideal and fairly simple conditions, that fact must give other nations pause. The reasons for success or failure should be carefully analyzed.

When a free country, through the democratic process of voting, decides to surrender its freedom in return for the benefits of social security, one may well ask what was back of the vote. Did the people understand what they were giving up and what they would receive in return? Was it truly a people's movement? What part, if any, did politics play?

BEGINNINGS OF NEW ZEALAND LAW DATE BACK 20 YEARS

The legislative history of New Zealand's program for socialized medicine is of particular interest to us, because in many respects it parallels our own. It goes back to the year 1927, when there was presented to the League of Nations a draft convention whereby signatories agreed to introduce discussion of national health insurance into their legislatures. The New Zealand representative was one of the signatories. The United States, not being a member of the League, was not at that time committed to work for the imposition of national health insurance on its people.

New Zealand, because of its commitment to the League, made an inquiry into the subject of national health insurance in 1929, and in 1934 the Hospital Boards' Association issued a tentative draft scheme for that country. The following year the council of the New Zealand branch of the British Medical Association set up the national health insurance committee to investigate the question. After studying conditions in New Zealand for 2 years and after examining the health insurance schemes in other countries, the committee came to the conclusion that conditions there differed materially from those in other countries and that *adoption of any of the systems already in existence "would not be suitable in New Zealand and would not make for those advances in medical service which are most desirable."*[1]

Late in 1935 there was a general election. Three parties contested. *All three included a national health insurance plank in their platforms.* The Labor Party won by an overwhelming majority. Early in 1936 the New Zealand branch of the British Medical Association offered its cooperation to the new Minister of Health, the Honorable Peter Fraser. A seemingly cordial relationship was established at the start, and Fraser agreed to give his confidence to the medical profession in formulating changes in the health system of that country. It soon became apparent, however, that the Minister of Health did not have it within his power to give to the profession the confidence he had promised. "From that day to this," wrote Dr. J. P. S. Jamieson in 1941, "the association has never known, except by inference, what the intentions of the Government really were, or how, exactly, it was proposed to proceed."

J. P. S. JAMIESON, M. D., KNOWS THE STORY BEHIND THE STORY

The legislative history of New Zealand's law for socialized medicine has been written by Dr. Jamieson,[2] of Nelson, New Zealand, and by Dr. Douglas Robb[3] of Auckland. Dr. Jamieson has been in practice in New Zealand for nearly 40 years and has worked closely with the Government during the past 7 years while it was endeavoring to nationalize medicine. Now actively engaged as a general practitioner and surgeon, he was for 7 years in contract practice and later spent 5 years as surgeon and medical superintendent of an 80-bed hospital. For the past 27 years he has been in private surgical and general practice. From 1917 through 1932 he was an examiner for degrees in forensic medicine and pharmacology for the Medical School of the University of New Zealand. Prior to settling in New Zealand he spent 3 years in hospitals in Britain and South Africa. He has occupied nearly every office in the New Zealand branch of the BMA, including the presidency, and throughout his medical career has been a member of the BMA. He has been closer to the nationalization movement probably, than any other physician in New Zealand, having been behind the scenes as an active participant throughout the entire period of Government action. He speaks with authority and from personal experience.

GOVERNMENT'S HEALTH INVESTIGATION NOT IMPARTIAL

During its first year in power (1936), the Labor government undertook to study health conditions in New Zealand preparatory to enacting comprehensive social-security legislation. An investigation committee was set up which "consisted wholly of members of Parliament of the Government's own party and did not include a single individual having the knowledge or experience suited for a task involving technical, scientific, professional, and actuarial questions, and judicial impartiality."

---

[1] Jamieson, J. P. S., M. D., The Medical Profession and Social Security Medical Services, 1941, Wellington, p. 2.

[2] Jamieson, J. P. S., M. D., Ibid. Also, private communication to the author, dated July 7, 1947.

[3] Robb, Douglas, M. D., Medicine and Health in New Zealand, 1940; Health Services or Doctors and Hospitals, Wellington, 1941; and Health Reform in New Zealand, Auckland, etc., 1947.

Dr. Jamieson noted in retrospect: "There is reason to believe that the mind of this committee, in a general sense, was made up before ever its investigation was begun, and there is little indication that attention was paid to any evidence, excepting to such views as lent support to its preconceived ideas."

The medical profession simultaneously was carrying on its own investigation. After studying all aspects of the health programs of New Zealand, the profession early in 1937 recommended:

1. Greater attention to preventive medicine and research;
2. Better coordination of the hospital system;
3. Complete service for those whose circumstances precluded them from being able to obtain medical attention for themselves; and
4. A contributory system of insurance for all others to enable them to provide against the major hazards of hospitalization, laboratory investigation, and specialized treatment.

In advocating Government action in these four fields, the New Zealand association expressed the opinion that the family doctor's services should be provided by private arrangements between doctors and patients. Only in the case of the poor and in instances where distance was a factor was there need of Government intervention in the provision of medical care by family physicians.

"EVERYTHING IS POLITICAL"

The Government paid little attention to the recommendations of the medical profession. Government officials had already made up their minds about a taxation plan for social security and about the establishment of a national compulsory sickness insurance scheme. (*The parallel with what is happening in the United States is striking.*) They had decided to set up a universal general practitioner service to be financed by a tax of £1 per head of the population. The Government's investigation committee submitted its report and recommendations to the Minister of Health, *refusing to show them to representatives of the medical profession.* The association maintained its position, asking that changes be brought about in an evolutionary fashion. It insisted that what was need most was *improvement of the general standards of health of the people*, "which health insurance has never shown itself capable of effecting, being but an indemnity for sickness."

Early in 1938 the New Zealand Medical Association presented a carefully prepared report to the Government. An attempt was made to explain "the curiously personal nature of a doctor's work." The report points out that "medical service does not lend itself readily to terms of contract like the supply of a definite number of standard articles, or the giving of so many hours of specific work. * * * *Modern methods of mass-production and the moving work-platform are not suitable for medical work.*" [Emphasis mine.] Dr. Jamieson, in discussing that report, said: "The fallacies of the questions of assumption put by the Ministers are exposed. It emphasized the human qualities of medical service and the professional outlook. It ought ot have put an end to all ideas of treating the people as pathological entities at so much per item."

When the association representatives presented their report to the Minister of Health, Peter Fraser, and the Minister of Finance, Walter Nash, they suggested that the desire for a universal medical system arose from political considerations rather than those of practical necessities. Mr. Nash interjected: "Well, everything is political."

A social security bill was drafted. Hearings called in 1938 were something of a farce. "Evidence was taken, but the decisions had been made already, and no point adverse to the preconceived idea was accepted. Even the well-based, cautious advise of an experienced actuary lent by the British Government was brushed aside." A statement was submitted by the association to the parliamentary committee, but again it was evident that there was no intention of making a dispassionate inquiry into the technical questions relating to national health. "The association was fully justified," says Dr. Jamieson, "in its contention that there should have been investigation by a disinterested, specially qualified, and nonpolitical body."

Representatives of the medical profession were kept in the dark as to the medical benefits of the social security bill and were not permitted to see the bill. Walter Nash simply announced that it provided for a universal scheme. Without rhyme or reason the Government combined its universal free medical care bill

---

[4] Official statement of the British Medical Association quoted by Douglas Robb, M. D., Health Reform in New Zealand, 1947, p. 18.

with the administrative rules and regulations which the physicians had drawn up for their own health program. The hybrid medical benefits legislation, drafted without the help and advice of the profession, and in wholly unworkable form, was finally enacted in 1938 as part III of the Social Security Act of New Zealand. That act was in general a forerunner of the omnibus Wagner-Murray-Dingell bill of 1943 (S. 1161 of the 78th Cong.). The similarity between the two pieces of legislation is due to the fact that both were drafted in conformity with principles laid down by the Socialist-dominated International Labor Organization.

NEW ZEALAND'S FREE HEALTH BENEFITS

Under the New Zealand Social Security Act of 1938 five major classes of free health benefits were to be made available to all persons ordinarily resident in that country without regard to economic status, race, or nationality. The five classes of benefits were: (1) Medical benefits; (2) pharmaceutical benefits; (3) hospital benefits; (4) maternity benefits; and (5) such supplementary benefits as were deemed necessary to insure effective operation of the first four benefits, e. g., specialist and consultant services, dental services, home nursing services, and domestic assistance.

The Social Security Act authorized the Minister of Health to determine the dates on which the several benefits were to commence. As the program developed and the law was amended, additional types of benefits were made available, until now there are eight free health services. Ironically, the first benefits to be put into operation were free maintenance and treatment in State mental hospitals. These became effective on April 1, 1939. Maternity benefits commenced on May 15 of the same year. In-patient treatment, under the hospital benefits provisions, commenced on July 1, 1939. Limited out-patient benefits became available on March 1, 1941. The latter include, free of cost to the individual, all medical, surgical, or other treatment afforded to a patient by the staff of the hospital, *except:* dental treatment, drugs, medicines, or appliances not taken or used at the hospital, diagnostic X-ray services, laboratory services for bacteriological or pathological purposes, and home treatment to out-patients. The excepted drugs and services for out-patients became effective May 5, 1941, the X-ray diagnostic services on August 11, 1941, and the massage benefit on August 19, 1942. Thus, as the law has worked out and has been amended, it now calls for eight general classes of free health benefits: (1) Free mental hospital treatment; (2) free hospital treatment; (3) the maternity service; (4) free X-ray diagnostic service; (5) massage and physiotherapy service; (6) pharmaceutical service; (7) the medical services—general medical or general practitioner service, specialist service; and (8) free laboratory service.

GOVERNMENT UNABLE TO KEEP PROMISES

The New Zealand Government encountered considerable difficulty when it endeavored to put the medical benefits into effect in February 1941. Before enactment of the law, the medical profession had suggested that payment be made by an adaptation of the "payment by attendance" method, then in use in many lodges, whereby the patient pays part of the fee for medical care. *The Government, however, had refused to consider any scheme that interposed a payment between the patient and his physician.* Negotiations having broken down on this fundamental question of the method of payment, the Government had introduced its social security bill without showing it to the profession. The bill had become law. The social security tax had gone into effect. Free medical services had been promised to the people in return for the new tax.

"The Government was in the position of a broker who had sold to the public (and taken the money) something which he did not possess, had made no arrangements to obtain, and was unable to deliver."

METHODS OF PAYMENT

An early attempt to institute a capitation system failed, except in a few rural areas. Physicians in the main invoked the principle of noncompliance. The Government was stymied. Two years passed during which the Government collected the social security taxes but failed to give the promised "free" medical care. The people went on making their arrangements for medical care on a private basis as they had always done. Finally, the Government receded from its original position and in 1941 amended the law so that physicians could make a direct claim on the social security fund for services rendered. The capitation system was retained under the original medical benefits law, but four additional systems were put into operation, all running concurrently with the capitation system.

There are thus five methods of payment for general practitioners in New Zealand at the present time: (1) Salaried basis, (2) capitation, (3) direct claim, (4) refund basis, and (5) the token system. Physicians may work on a *salaried basis* in areas proclaimed to be "special areas" by the Minister. The method works fairly well, especially in rural communities where there is only one physician. Under the *capitation system*, a physician receives 15 shillings, about $1.50, per annum, plus an allowance for mileage, for every patient on his list. Under the *direct claim* method every patient attended signs a form acknowledging the attendance. The social security fund pays 7 shillings 6 pence (87 cents at present exchange rates) for every attendance, the amount being increased to 12 shillings 6 pence for attendance between 9 p. m. and 6 a. m., on Sundays, or on statutory holidays. Mileage is paid each way, outside a radius of 2 miles. Under the *refund method*, the patient has the option of paying his physician the regular fee and of presenting an itemized, receipted bill to the social security fund for a refund at the same rate and mileage as that provided under the direct claim method. Under the *token system* the patient pays a "token" fee (usually 3 shillings), signs a form stating that service has been rendered, and the doctor collects from the Government once a month on the basis of the number of signed forms.

QUANTITY RATHER THAN QUALITY OF SERVICES COUNTS

Probably half or more of doctors in general practice are following the direct claim method, according to Dr. Jamieson. "It is a bad way," he says, "as can be seen readily. It is the number of attendances, not efficient diagnosis and treatment, requiring time and care, that brings good income. Numbers, not skill: quantity, not quality. There is an inducement to overattendance and trivial attendance, to which patients make no demur, because they do not pay each time; and there are various possibilities of racketeering, as easily can be imagined. The cost is rising year by year. Yet it is greatly to the credit of New Zealand doctors that it has not risen more. There is no doubt that a majority of doctors who follow this method do their best to give honest service. Nevertheless, it is having a deteriorating effect upon the standard of practice, gradually, not only from the temptations it offers but for the following reasons: In the haste to work through numbers there is a tendency to side-step anything difficult or time-consuming by referring it to the public hospital." Thus the patient is likely to receive *quantity* rather than *quality* service and may be hospitalized unnecessarily if his case is too time-consuming. The physician, for his part, because of the modest size of the Government fee, may be tempted to treat a large number of patients cursorily or to perform a number of routine services which a nurse or clerk could do. Each service performed will be paid for by the Government at the rate of 87 cents each and will increase his income. In addition, there is a long-time deteriorating effect on postgraduate medical education and on the development of the highest skills. Dr. Jamieson points out that—

"* * * formerly, upon graduation, a young doctor, as soon as he had done a period as intern in a hospital, set to work, often at great sacrifice, to gain further experience abroad and obtain senior degrees in order to qualify himself for good work and good fees. Now, the thing that attracts the new graduate is apt to be *to get out into 'direct claim' practice as quickly as possible to make money—the same object by an inferior method.* The longer this system lasts, therefore, the lower will fall the standard of the work. The full effect has not yet been seen." [Emphasis mine.]

ADVANTAGES OF REFUND METHOD

In the opinion of Dr. Jamieson, the refund method of payment, on the whole, is the best for both patient and physician, inasmuch as it enables the doctor to devote the time and care he deems necessary, while the patient receives, in return for his social security tax, a partial indemnification for the cost of his medical care. "Of the four possible methods [counting the 'token' payment as a specialized type of refund] it is the one that best preserves the integrity and professional incentives of the doctor and the quality of service for the patient."

The refund method, which was recommended by the New Zealand branch of the British Medical Association, is the one used by most senior men, but it does not find favor with the Government. Doctors have found certain disadvantages in this method because of the cumbersomeness of the refund mechanism and because these is difficulty in adhering to it in competition with colleagues who are using the direct claim method. Consequently, in some cases, resort has been had to the doubtful expedient of using the direct claim method for poorer patients and the refund method for those better off.

The Government, for its part, has encountered administrative difficulties in handling the cases under the refund method, for it is more difficult to process thousands of individual claims from patients than it is to take care of a few hundred consolidated claims from physicians. On the other hand, the refund method leaves the physician free, without spoiling the relation between patient and doctor, and enables him to continue to be the servant of the patient. The New Zealand Government, wishing to make the doctor the servant of the state, has been dissatisfied with the freedom achieved by the profession under the refund method and has threatened to repeal the law authorizing payment in this manner. Indeed, the Government at one time proposed enactment of a law forbidding the private practice of medicine, and it is feared that the Government may still so act.

METHOD OF PAYMENT AFFECTS MEDICAL PRACTICE

It is evident that the method of payment has far-reaching effects o the content and the quality of medical care, statements to the contrary notwithstanding. In New Zealand the several systems in effect tend to administrative confusion, racketeering, abuse by patient and physician alike, rising costs, and deterioration of service. If it be conceded that there are defects in the present fee-for-service system under free medical practice in countries where medicine has not been socialized, it must also be admitted that the proposals for systems under government control, such as those operating in New Zealand, have drawbacks at least as serious as those in an uncontrolled economy.

ADMINISTRATION

Consideration of the administration of the medical benefits brings us to the very heart of the public medical-care plan. Ordinarily, scant attention is paid to administrative problems in advance of enactment of laws to nationalize medicine. Neither the public nor the legislators wish to be bothered with "the details of administration." They prefer to leave such matters to the "experts"; that is, the Government officials who are to administer the laws. *That is a fatal error, for in the administrative procedures and rules and regulations lie the inescapable evils of public medical care, whether under social insurance or nationalization.* The reason is not far to seek: Disease and ill health are individual matters. They do not lend themselves to statutory or bureaucratic regularization. *A physician's services cannot be weighed and measured like commodities in the open market.*

If the practice of medicine is to be so revolutionized that the patient no longer makes his own arrangements for medical care, and if the government, not the patient, pays the doctor, the hospital, the pharmacist, and the technician, then it becomes necessary for the government to define the services and commodities for which it will pay. If payment is on a fee-for-service basis, the service must be defined. The government by regulation must state how much it will pay for a specified number of minutes of a doctor's time or for specified services. It must list drugs which may be prescribed. It must decide what is specialist service and what is not, who is a specialist, and when the services of a specialist are warranted.

In policing the socialized medical-care system, public officials must be employed to check on all health and medical personnel. There must be referees, investigators, appeals boards; there must be staffs to devise endless forms; there must be other staffs to call for reports, and still other staffs to analyze the reports. Laws and regulations must be constantly in a state of flux, as amendment follows amendment and revision follows revision. While neither diseases nor methods of treatment are static, laws are rigid. Rules and regulations having the effect of law are themselves inflexible. They cannot be fitted to the needs of individuals. *The lag between ponderous, often stupid,* *bureaucratic procedures and the quick advances of science is one of the primary defects in government-controlled medicine, whether it be public medical care or compulsory sickness insurance.*

Government interference in the practice of medicine appears to be no worse in New Zealand than in other countries which have adopted a system of complete or partial nationalization. The government defines medical benefits as "all proper and necessary services of medical practitioners" except those given under other titles of the law and specialist services. Application forms and agreements are available at any post office or district health office. The application is made out by the individual and presented to the physician of his choice. If the doctor is willing to accept the terms of the government, he signs the agreement and forwards it to the medical officer of health for the district in which the patient resides. This officer issues to the person concerned a medical benefits card which constitutes evidence of the person's right to medical-benefits from the doctor named on the card. Thus the responsibility for finding a doctor who will work under government contract devolves upon the patient. Dr. Jamieson, after commenting on the fact that the government was in the position of the broker who accepts money and promises to deliver something he does not have, stated that under the revised law the government was in the position of the broker who "has confessed his inability to fulfill his contract, and says to his clientele—'If you can get this for yourselves, I will pay.' "

LIMITATIONS ON FREEDOM OF CHOICE

For all practical purposes, the general practitioner is limited to patients who live near him. Patients may find it difficult to retain the doctor of their choice if they move away from the immediate neighborhood in which the doctor lives. Restrictions on patient choice are brought about by limitations on the payment of mileage from the social security fund. Freedom of choice of physician and of patient is of the limited variety, customary under government medical programs. Such freedom as there is is exercised at the time of entry into the system. Changes are made only after delays and red tape. When it is realized that a person while in good health ordinarily has no particular interest in changing his physician, it will be seen that from the patient's point of view there might be serious draw-backs to a Government regulation which is thus worded:

"In any case where a patient desires to change his doctor, the transfer becomes effective immediately if both doctors agree to the transfer. If, however, the doctor affording benefits does not consent to the transfer, the transfer does not become operative until the expiration of the month following the month during which notice of the proposed transfer is received by the medical officer of health." One can well imagine that in many cases where the patient or the patient's family has reason to make an immediate change which is resisted by the attending physician, the need for such change might no longer exist a month hence if the patient were dead.

Under the "general medical services" benefits law which went into effect on November 1, 1941, and which provided for the "direct claim" method, as opposed to the capitation method of payment, a medical practioner receives 7 shillings 6 pence (87 cents) for services requiring 30 minutes or less. If he physician requires more time, he may file a claim for additional remuneration with the medical officer of health. One can well imagine that the physician whose primary interest is in his patient might spend more than 30 minutes without keeping his eye on the clock or taking the trouble to fill out a Government claims form for 10 minutes or 30 minutes of overtime. One can also imagine that the specification by the Government of a certain unit of time to be paid for at a certain rate might tend to make that unit the accepted one, with resulting standardization and the development of assembly-line medicine.

COSTS OF SOCIAL SECURITY BENEFITS

The New Zealand Department of Health reported for the year ending March 31, 1946, that the total revenues for the year, including social security taxes, income tax, customs, etc., had amounted roughly to £79 million. During 1945–46 the total costs of all social security benefits and health services had amounted to £31.4 million, or approximately 40 percent of all the national revenues. The Minister of Finance, Hon. Walter Nash, estimated that for the year 1946–47 social security expenditures would amount to 35.8 million pounds, while the social security taxes, which had been increased, would yield only £20 million. Already, after only 6 years of operation of the Social Security Act and before all the promised benefits are in force, the Government is being asked to contribute to the social security fund out of general revenues nearly as much as is being raised by social security taxation.

Although the social security program was supposed to be financed by a special earmarked tax of 5 percent on wages and other income, the costs had risen so much by the end of the fifth year of operation of the free health benefits that the total outlay for all social security benefits represented 10 percent of wages and a per capita cost of 18 pounds 12 shillings for each person in the population (44.64 at present exchange rate of 1 pound=$2.40).

Expenditures for drugs have trebled, with the result that the per capita cost of pharmaceutical benefits is nearly as high as for medical benefits. Incomplete medical benefits, exclusive of specialist services, dental services, and home nursing care, already cost 3 pounds 5 shillings 5 pence per capita per annum, or $7.83 at present exchange rates, which are one-half normal. If the cost of the health benefits (health department, mental hospitals, etc.) is added to the medical, hospital, maternity, pharmaceutical, and supplementary benefits, the total per capita cost for the year 1945–46 is seen to amount to 6 pounds 7 shillings 3 pence, or $15.26. At normal exchange rates this would about $30.50 per capita per year.

Total cost of all social security benefits and health services, 1945–46 [1]

		Pounds
Total		31, 399, 096
Civil pensions		16, 701, 422
War pensions		3, 938, 192
Medical categories		5, 536, 564
Maternity	£600, 209	
Medical	1, 427, 309	
Hospital	2, 173, 460	
Pharmaceutical	1, 133, 366	
Supplementary	229, 971	
Total	5, 564, 315	
Less recoveries	27, 751	
Net total	5,536, 564	
Health department		3, 031, 549
Mental hospitals		940, 166
Hospital board levies on local authorities (1943–44 latest figures)		1, 251, 183

[1] Data from the annual report, department of health, for the year ended Mar. 31, 1946, from the budget speech of Hon. W. Nash, Aug. 15, 1946, and from other official sources.

In order to meet the rising costs of social security benefits the subsidy from general revenues was increased 157 percent from 1945–46 to 1946–47; that is, from £7 million to £18 million. And the end is not in sight.

CRITIQUE OF NEW ZEALAND'S FREE HEALTH BENEFITS

The eight free health benefits of New Zealand have now been in effect for periods varying from 5 to 8 years. The less personal benefits, such as laboratory services and X-ray diagnostic services, have been more successful than have those involving care of patients by physicians in their offices, in hospitals, and in the homes of patients. The present status of the several free services is as follows:

Free mental hospital treatment.—There has not been any great change in organization, since mental hospitals had been state institutions ever since New Zealand governed herself. "The only difference is that some £150,000 per annum previously paid by patients' estates or by their friends is now paid from taxation."

Free hospital treatment.—The services are paid for partly from social security funds, partly from taxes. Free treatment has undoubtedly helped many who would otherwise not have had care. On the other hand, "It has naturally caused a run on hospitals which these have been unable to cope with." Although New Zealand has the highest ratio of hospital beds to population of any country in the world, there are still not enough beds because of the use of hospitals for trivial illnesses and because of other abuses. Furthermore, the tendency is for the "free hospital" to become a "closed hospital," staffed by full-time, salaried doctors. Because of the run on hospitals, admission of chronic, semichronic, and senile cases has been drastically restricted.

The maternity service.—The medical profession in New Zealand has always been sympathetic toward a free maternity service. The plan originally proposed by the Government was repugnant to patients and doctors alike. The Government's offer of contract was simply not accepted by the profession. Finally, in 1940 the original Social Security Act was amended. Doctors now are not required to enter into a Government contract but are allowed payment from the social security fund at specified rates. If they choose not to accept such payments they are left free to practice obstetrics by private arrangements amongst patients willing to pay their own way. While the profession thus came to a compromise with the Government, insofar as maternity benefits were concerned, they made it clear that they regarded those particular benefits in a different class from general practitioner benefits. Maternity care is for a limited condition, a self-limited sex, and a limited period. It is not susceptible of the same types of abuse by physicians and patients as characterize a free general practitioner service. The profession was willing to accept definite sums on a prearranged-fee scale. They were not willing to "*accept, for any predetermined sum under predetermined conditions, the vast, unlimited, indeterminate sickness risk involved in general practitioner service.*"

Free X-ray diagnostic service.—As the law originally stood, this service "was a failure and threatened to ruin every private radiologist." A compromise was effected, and now physicians are able to secure diagnostic X-ray services at little or no cost to patients at public hospitals, while approved radiologists receive part of their pay from the social security fund, the balance from the patient. There are abuses on the part of doctors and of patients, leading to unnecessary radiology. X-ray and radium treatment have not yet been made available free, except to in-patients in public hospitals.

Massage and physiotherapy service.—This service is provided on the same basis as the X-ray service and is subject to the same abuses. It is, however, most useful.

Pharmaceutical service.—"Free medicine," says Dr. Jamieson, "has a restricted use and many abuses." It is a boon to persons of modest means to be able to obtain prescriptions at a moderate cost, and a boon to doctors to be able to prescribe what the patient needs without considering the patient's ability to pay. The chronic patient who needs medication, such as insulin, over a long period is greatly aided. Here it should end." Since the introduction of "free medicine," the consumption of medicine has trebled and is still rising. "The cost of medicines bids fair to outstrip the cost of general medical services." The reasons for this increase are the faith of the people in medicine and the ease of getting a free prescription under the free general medical service. A very large proportion of persons visiting physicians are not suffering from physical ailments; they are worried, depressed, anxious about some nonmedical condition. For the physician harrassed by large numbers of patients who are not ill, it is easy to write a prescription.

Free laboratory service.—This service has been available for only a few months. It is based on public hospitals, but approved practitioners may participate on scheduled fees. Abuses are not very likely. The advantages are great. Dr. Jamieson states: "I find this service and the X-ray service the most real benefits we have obtained through social security."

The medical services.—These are the most controversial of the benefits and the most difficult to administer. They will be discussed in a separate section.

FREE MEDICAL SERVICES IN CHAOTIC CONDITION

As of June 30, 1947, the free general medical service and the general practitioners service of New Zealand were in a "chaotic condition." According to Dr. Jamieson, they "had better be shunned." [5]

The capitation method of payment, which is one of the methods proposed in the Wagner-Murray-Dingell bill and which Michael M. Davis has stated would be the method that would probably be adopted in the United States if that bill were passed, *failed in New Zealand despite Government support.* Even the ILO has pointed out the weaknesses of the capitation method, which remunerates doctors in inverse ratio to the amount of service they give. As the New Zealand Medical Planning Committee pointed out, the capitation method makes budgeting and disbursement easy, but it leaves the physician holding the bag for "*an unlimited and undefined liability of sickness is disposed of for a defined cost. * * * Why should the medical profession undertake the unlimited range of general practitioner service for any prescribed sum?*"[6]

---

[5] Private communication from J. P. S. Jamieson, M. D., dated June 30, 1947.

Dr. Douglas Robb has criticized severely both the free hospital service of New Zealand, which is a socialized service of long standing, and the newer free medical services. "On the clinical side," he says, "there is not a great deal to be particularly proud of, though some hospitals do better than others. In general, it may be fairly stated that, with the exception of Dunedin Hospital, to which is attached the medical school, no public hospital has as yet consciously embraced medical progress and research amongst its objects."[7]

With respect to general medical practise, Dr. Robb refers to one of the great dangers of nationalization of medicine, namely, the fact that *the organization of medicine which exists at the time of nationalization tends to be crystallized.* Advances are retared; experimentation in better organization becomes impossible. The downward leveling of the quality of medical care and the rigidifying effects of bureaucratic control tend in the long run to produce professional apathy and public indifference.

"ONLY MAKE IT UNIVERSALLY AVAILABLE"

After more than 5 years of experience with politically planned free medical care, Dr. Robb says: "Perhaps the worst feature of the present arrangements for general practice lies in their assumption that the style and scope of general practice as we knew it before 1940 was good and left nothing to be desired. Only make it universally available, and all will be well. The truth is that many medical leaders had become more than doubtful of this proposition and were trying to wean both people and doctors away from their addiction to the old style and methods with their inevitable bottle of medicine. Far from helping this endeavor, the Social Security Act has confirmed the old methods and entrenched their already vested interests with richer rewards than ever. The demoralization of the profession has proceeded steadily, and it is becoming harder to fight a way out. When the inevitable recriminations begin, and a once 'noble' profession is pilloried for its mercenary attitudes, we must in fairness remember that it did not conceive nor initiate the present scheme. It may have failed to propose an acceptable one which was better, it may have meretriciously connived at it when established but it did not lay the bad egg."[8]

In the *Draft Final Report* of the Medical Planning Committee issued in July 1944 it is pointed out that the medical profession diverges from the Government in the totalitarian concept of "free, universal medical service." The Committee stated:

"This term may have use as a figure of speech. Literally, however, it is inconsistent with rights the people of this country have held in the past, inherited from centuries of struggle by their British ancestors. For it implies that everyone must accept, without alternative, the service provided by the Government, and that those rendering the service must accept, without alternative, employment by the Government. This position, when clearly understood, we believe, could never be approved by the people or the doctors."[9]

SUMMARY

When the comprehensive Social Security Act of New Zealand was enacted in 1938 it contained a title on health benefits. Free medical care, hospital care, maternity services, diagnostic services, laboratory services, drugs, and other benefits were promised to all members of the community. The medical profession was not consulted by the Government in the drafting of the legislation. The Government's investigation of health needs was perfunctory. Decisions regarding the inauguration of a universal scheme of compulsory sickness insurance were made by the Government with little or no regard for professional recommendations. Proposals by the medical profession were not heeded. When the Government established its system of free health benefits the order for instituting programs was *the reverse* of that recommended by the profession.

The program was initiated with difficulty because (1) the law was unworkable, (2) the Government had promised free medical care services without consulting the professions involved, and (3) the attempt to force the medical profession to work under a capitation system failed. For 2 years physicians resorted to their legal right and professional privilege of refusing to participate in the Government's plan. Concessions were made by the Government, especially with respect to methods of payment. Medical practitioners are now reimbursed in five different ways, with resultant administrative confusion. Racketeering has developed among physicians and patients. Hospitals are crowded with trivial cases not in need of hospitalization. As a result, chronic patients are neglected and nurses and physicians are overworked.

---

[6] Draft Final Report, Medical Planning Committee, New Zealand, July 1944, p. 8.
[7] Robb, Douglas, Health Services or Doctors and Hospitals, 1941, p. 11.
[8] Robb, Douglas, Health Reform in New Zealand, 1947, p. 36.
[9] Draft Final Report, Medical Planning Committee, New Zealand, July 1944, p. 4.

Costs have skyrocketed and are still going up. The national use of drugs has trebled. Free prescriptions are easily obtained. Busy doctors can satisfy many patients with prescriptions. Since these do not cost anything at the time they are obtained from the pharmacists, the popular demand for drugs is increasing. There is too great faith in the efficacy of a bottle of medicine.

The entire social security program, although not fully established, is absorbing over 40 percent of *all* tax revenues, both general and social security. The social security taxes are meeting a little over half the total cost of the free benefits. The deficit is being taken from general revenues. After only 8 years of operation of the omnibus social security program, the Government, in an effort to bail out the collapsing system, poured into the social security fund over one-fourth of all general revenues collected from all sources. Insofar as health and medical benefits are concerned, costs are excessive. National expenditures for drugs have trebled. Physicians, being paid for *quantity* not *quality* of services, have multiplied attendances at 87 cents per item and have busied themselves with trivial activities paid for at the same rate as difficult procedures requiring great skill. The leveling process is in full swing. Research and medical education suffer. Hospitals have closed staffs of salaried doctors.

Patients are obtaining more health services but are not necessarily achieving better health. They consume more drugs, call on physicians more often, enter hospitals more frequently. There is no specialist service. Free X-ray diagnostic services and laboratory services appear to be working fairly well, though there are some abuses. The maternity services are moderately successful, though all the personal medical services suffer from Government interference and regulation of patients and physicians. Patients entering public hospitals may not have the services of their personal physicians but must accept the salaried doctors on the closed hospital staffs.

Changes are imminent to avoid collapse of the free system. Doctors may be put on a salary and may be forbidden by law to engage in the private practice of medicine.

THE NEW ZEALAND MEDICAL PROFESSION FIRM AGAINST STATE HELOTRY

In 1941 Dr. Jamieson stated the view of the medical profession. Succeeding events have justified the profession's apprehensions and have shown the soundness of its professional stand. Medicine and politics do not mix, nor medicine and bureaucrats.

"The purpose of the Government's scheme," said Dr. Jamieson, "in keeping with its general policy, is to subordinate medicine, and all that pertains thereto, to the all-controlling state. * * * As one party succeeds another in power, it is seen, rarely if ever, that the party coming into office lays aside any of the powers taken by its predecessor, however much, in opposition, it may have protested against their assumption. Consequently, the association places no trust in the future if it yields anything now.

"In the wider view, governments, departments, boards, and hospitals are not the employers of the medical profession. They are but agencies through which the work of the profession may be made more effective for the people. Governments come and go, and their form varies. The [social security] department is still young. Boards are evanescent, and hospitals perishable. While there are men and women and children, the science and art of medicine, in its widest sense, will always remain. The profession is determined that its tradition of service to the people as individuals and human beings, not as pathological entities, will be preserved in this country. It will not submit to a condition of State helotry." [10]

---

[10] Jamieson, J. P. S., The Medical Profession and Social Security Medical Services, 1941, afterword.

NOTE.—Material in this paper is based on (1) several interviews with Hon. Walter Nash when he was in the United States in 1943 and 1944 as Minister Plenipotentiary from New Zealand, (2) numerous official reports and regulations, and (3) articles in The Lancet, the Supplement to the British Medical Journal, the New Zealand Medical Journal, and the International Labor Review. The author is particularly indebted to recent unpublished correspondence with Dr. J. P. S. Jamieson.

Dr. SHEARON. We have heard a great deal about New Zealand and a great deal that was not true. In that country the system has gone broke financially. It has done great damage to the cause of medical care. I have a tremendous amount of information on it, and I have incorporated the highlights of that information in this brochure. Much of the material has not been published before, and I think it would be of great service to know what really has happened in New Zealand, because this is right-up-to-date information. The law is new, and yet in spite of that 5 years from the time the medical care program was put into action the whole scheme is in a state of collapse.

I feel that a great deal of misrepresentation has gone out about the New Zealand system. I have a large number of newspaper articles on the subject, but since they are rather a matter of common knowledge. and furthermore, we have had most of them in the hearings already, I have confined my present discussion of New Zealand to what I have brought out in this brochure, which is for the most part new.

Senator DONNELL. Dr. Shearon, coming over from New Zealand to Rhode Island, I observe among those present this morning Miss Elizabeth W. Wilson, and I have here an article by her which is very recent, May 15, 1948, entitled "Sickness Pays in Rhode Island—Malingering Poses Problems as Workers Make More at Home Than on the Job." Have you seen this article?

Dr. SHEARON. No.

Senator DONNELL. Would you have any objection to having that article incorporated following the items which you have incorporated in the record, following your testimony?

Dr. SHEARON. It might be better to have it after the section I have to take up next on costs. Or, put it in at the end.

Senator DONNELL. This article will be incorporated in full at the conclusion of your testimony, or following some of the items that have already been put in.

Dr. SHEARON. And as long as you mention Rhode Island, I might say that the Social Security Board had a tremendous amount to do with having the Rhode Island law passed. Mr. Falk was extremely anxious to have such legislation tried out in some one State, and it certainly had definite results in Rhode Island. He has worked on the assumption that if you can't put the Wagner-Murray-Dingell bill through, then get it through piecemeal by getting the States to pass such legislation. He worked very hard behind the scenes.

Coming to the question of cost, although this subcommittee is not directly responsible for passing on legislation dealing with taxation, I think you would not wish to approve a bill that would in all likelihood tend to bankrupt the country. Again it is necessary to view S. 1320 in its context in the total scheme of national social security. This particular bill would depend for financing on a charge of at least 3 percent on pay rolls: 1½ percent on employers; 1½ percent on employees. The deficit would come out of general revenues. Most of the time the question of costs is dodged by Federal officials, or not clearly presented. Yet it is a matter of great importance, not only to Congress but to the people at large. Everyone is worried about rising taxes. I wonder how many people would be enthusiastic about social security benefits and services if they were told in advance that after the omnibus social security program was in full swing it would take some 20 to 25 percent of the national income.

Even Mr. Falk himself some years ago stated that the health insurance program would probably cost 10 percent of pay rolls. I think that is an important admission. He said that several years ago, and since that time the proposed benefits have gone up decidedly.

Senator DONNELL. Do you have at hand the citation in which he made that statement?

Dr. SHEARON. Yes. This was back in 1944. It was in one of the papers that was given at an American Public Health Association meeting on October 4, 1944, at the time of the rigging of the platform of that association. Mr. Falk spoke on unmet health needs, and although there has been frequent testimony here to the effect that medical care insurance would cost perhaps three billion to four billion a year, Mr. Falk inadvertently let slip at that time that he thought it might rise to considerably more. He said that in the years ahead, especially if our economy operates at a high level of employment, our total expenditures for health and medical services might advantageously be extended from the four billion of pre-war years to as much as five billion, six billion, or even nearly seven billion a year, under arrangements that would make adequate services and care available to the entire population. He said these larger amounts for the future might be only 6 percent of the national income. That is just for the medical services. Then he goes on to discuss the amount that would be needed for the cash sickness expenditures, and disability cash benefits. The cash sickness expenditures he estimates at 1 percent; permanent disability, 3 percent. Add that to the 6 percent and it makes 10 percent of pay rolls. And that is quite independent of the charges on pay rolls for old-age insurance. That is, of coure, a major item of expense in the social-security system.

(Pursuant to her discussion of citation, Dr. Shearon submitted the following:)

Excerpt from Unmet Health Needs, a paper presented before the American Public Health Association, October 4, 1944:

"In the years ahead, especially if our economy operates with stability and at a high level of employment, our total expenditures for health and medical services might advantageously be expanded from the $4 billion of prewar years to as much as $5, $6 or even $7 billion a year under arrangements that will make adequate services and care available to the entire population. These larger amounts for the future might be only 6 percent of the national income. This should be compared with the 5 percent of national income (a total of about $3 billion) expended about 10 years ago in times of deep economic depression when the degrees of economic freedom and the margins of flexibility in our expenditure patterns were very low indeed. These and all such figures should be measured against the $10 billion commonly accepted as a conservative estimate of the direct and indirect costs of sickness and disability."

Note: The $10-billion figure includes estimates of both the costs of medical care and the wage losses due to sickness. It is, therefore, not comparable to the $5 billion to $7 billion referred to by Mr. Falk, which relates only to medical care costs. Such loose and misleading statements are characteristic of Mr. Falk's presentations on costs. Thus, by lumping all direct and indirect costs of sickness, including not only medical care costs but also wage losses, he arrives at a $10,-billion figure for current national costs of sickness and disability. He inflates this figure so that it is more than the $7 billion for medical care which he contemplates under the compulsory insurance plan. In order to make the two figures comparable there would have to be added to the $7 billion for medical care another $7 billion, possibly, for wage loss. The total for postwar sickness and disability losses, computed on a comparable basis, would be about $14 billion under the Falk plan.

In order to pick up the remaining cost estimates for the Falk program it is necessary to consult other publications of his and of the Bureau of which he is director. In the autumn 1939 issue of Law and Contemporary Problems appears an article by Messrs. Falk, Reed, and Sanders entitled "Some Problems in the Formulation of a Disability Program," pages 645–665. The estimate of 1 percent of payroll is there given as the cost of temporary disability and maternity benefits. These are cash benefits to offset wage loss. The cost of permanent disability is expected to rise to 3 or 4 percent of payroll according to a memorandum from the Bureau of Research and Statistics dated June 26, 1943, entitled "Cost Factors Under the Wagner-Murray and Dingell Bills." All told, then, under the Falk scheme for compulsory insurance for medical care and cash sickness and disability benefits, taxpayers would be compelled to pay to the Federal Government sums equivalent to 10 percent or more of payrolls. This would not include the cost of capital investment in hospitals, health centers, and other facilities.

Dr. Shearon. So there is no question that the Government people are thinking ultimately in terms of 20 to 25 percent, and possibly more, of the national income for the social security program. In that connection it will be well to point out that, of course, they do not expect that to come from social security pay-roll taxes. That is not brought out very clearly, but they indicate that from time to time with the statement that the deficit will be made up from general revenues.

If this is to cost around 25 percent of pay rolls, and if ultimately you get to the point where you are charging the employee 6 percent and the employer 6 percent, there will be a deficit there of 12 or 13 percent of pay rolls, which will be made up out of the general revenues. In other words, we will have at least a 50-percent subsidy from general revenues. This is significant in view of the fact that there was an announcement in the paper last night—I forgot to bring it with me—that Mr. Snyder says that we will have to resort this year or next to deficit financing again—that is, without the extended social security program which is in contemplation—either deficit financing or very large contributions from general revenues. Now, what does that mean to all who pay taxes, to organized labor in particular, which is pushing this legislation? It means that in addition to the 6-percent charge on the pay rolls—in other words, every time a worker gets his pay envelope, 6 percent will be taken out for social security—there will be increased income taxes, which will again be taken out of the pay envelope. And I think you can see the large implications of this in labor troubles.

Senator Donnell. Doctor, do you have at your office the quotation from Secretary Snyder's statement to which you refer?

Dr. Shearon. Yes, I have.

Senator Donnell. Would you mind making that available to the committee?

Dr. Shearon. Yes, I will. As I say, I believe that labor and other tax-paying groups should and would think twice before paying that much into the Federal Government in order to get these benefits. Now, this is very much to the point, in view of the fact that on May 24—that was the day before yesterday—President Truman sent a message to Congress, urging the expansion of the whole social-security program, and calling for larger benefits for the persons who are already insured, for old-age insurance, larger public assistance payments, expansion of benefits to include cash sickness benefits, and cash benefits for permanent disability.

Senator DONNELL. Doctor, I would like to read into the record at this point, if I may, the following excerpts from the Report to the Senate Committee on Finance, from the Advisory Council on Social Security, which appears in Senate Document 149, 80th Congress, Second Session, Serial No. 74779, 1948, presented by Chairman Millikin on April 20, 1948, to the Senate, as follows:

> Government participation. The council believes that old-age and survivors insurance should be planned on the assumption that general taxation will eventually share more or less equally with employer and employee contributions in financing future benefit outlays and administrative costs. Under our recommendations, the full rate of benefits will be paid to those who retire during the first 2 or 3 decades of operation even though they pay only a fraction of the cost of their benefits. In a social insurance system, it would be inequitable to ask either employers or employees to finance the entire cost of liabilities arising primarily because the act had not been passed earlier than it was. Hence, it is desirable for the Federal Government, as sponsor of the program, to assume at least part of these accrued liabilities based on the prior service of early retirants. A Government contribution would be a recognition of the interest of the Nation as a whole in the welfare of the aged and of widows and children. Such a contribution is particularly appropriate in view of the relief to the general taxpayer which should result from the substitution of social insurance for part of public assistance.
>
> The council has suggested that the introduction of the Government contribution be considered when the 2-percent rate for employer and employee plus interest on the trust fund is insufficient to meet current costs. If the Government contribution is delayed beyond the point at which costs begin to exceed 4 percent, the result might well be that the contribution would never be as much as one-third of eventual benefit outlays, because under our low-cost estimates, the annual cost of the benefits never exceeds 6 percent of pay roll even though under the high estimates the cost reaches 9.7 percent.

Dr. SHEARON. Well, since you have referred to that report, I should like to point this out. It is one of the things that has disturbed me greatly, that this advisory council to the very important and powerful Senate Finance Committee has put out the report from which you just read.

Senator DONNELL. Pardon me, Doctor. This 9.7 percent to which reference is made in this excerpt from the report I have just read, refers, does it not, only to old-age and survivors insurance? Then there would be added to any amount of contribution to be made by the Government for those purposes, the contributions to which you refer, for expenses of Government health insurance.

Dr. SHEARON. Yes; certainly, and for these new benefits that are coming along. As I said yesterday, next week this very same advisory council is going to put out a report recommending cash benefits for permanent disability, to be tied to the old-age-insurance system, and then after that they will put out one on cash-sickness benefits.

Senator DONNELL. I am not quite clear about this last sentence.

Dr. SHEARON. What page?

Senator DONNELL. Page 13. I am not quite clear as to just what the council means by the 9.7. It says:

> "If the Government contribution is delayed beyond the point at which costs begin to exceed 4 percent, the result might well be that the contribution would never be as much as one-third of eventual benefit outlays, because under our low-

cost estimates, the annual cost of the benefits never exceeds 6 percent of pay roll even though under the high estimates the cost reaches 9.7 percent."

Dr. SHEARON. If the cost is 9.7, and 6 percent is taken care of through pay roll taxes that go into the social insurance fund, then the subsidy at the high level would be 3.7 percent of pay roll, but if it did not exceed 6 percent, it might not call for any Government subsidy.

Senator DONNELL. Is it your understanding that this indicates that the council think 9.7 is higher than the expenditures will actually go?

Dr. SHEARON. Yes; but, of course, what is happening is this—you can see it very clearly—the old-age insurance went into effect January 1, 1937. We have had it a little over a decade. That is a very little time for the old-age-insurance system. If this thing goes on for decades and decades, and you get more and more involved in it, it is like stepping into hot asphalt, you just never can get out.

Congress has gone along from the beginning by being told what wonderful benefits will be provided for everybody, that it will cost only 1 percent of pay roll. But the people who are doing the estimating behind the scenes are thinking in terms of 10, 20, 30, 50 years, 100 years hence, when they will get the full load, with an aging population.

For instance, by 1980, we will have 22 million old persons who will be coming in for these benefits. We will have a much larger proportion of the population, all seeking these benefits, and by that time they would have been in the system long enough to claim these benefits. So the old-age insurance is a very expensive part of the program.

While we are in the early stages, and before you get a chance to be too alarmed, they come along with these recommendations, as President Truman has come along on the 24th of this month with the recommendations for not only the extension of coverage so you get more and more people into the system, but also additional benefits, all of which are not too costly in the beginning. The law is full of all kinds of exemptions, so that people do not qualify, but after a while, as the system matures, more and more people do qualify and you begin to feel the impact of the real expensiveness of the thing. Then you are committed. No country is ever able to get rid of an old-age insurance system; they do not want to. But there is no way of getting rid of it even if they should want to.

The point has been made many times by Government officials that no country has ever rescinded a health insurance law. Why? They cannot, because, for one thing, when you have money paid into trust funds, you have a great many persons involved. Each one has a little in the fund, and he is hoping to get some of his money back some time, so he does not want the law repealed.

You get many Federal officials, with a very large bureaucracy developed. We see what pressures a bureaucracy like that can put on Congress. We have had a very good illustration of that within the last 2 weeks, with the Senate Appropriations Committee. When the House Appropriations Committee cut the appropriation for the Social Security Administration by a little over $3,000,000—the House Appropriations Committee cut it—the amount of pressure that was put on the Senate Appropriations Committee to restore those cuts was astounding. Federal and State officials came in and said "Restore those cuts. Do not ruin the social security system by cutting it in any way, by reducing any of the benefits, or by reducing the administrative staff, the research staff, or the informational staff."

Not only public officials, but also representatives of private organizations who had been working with those officials for a long time and had become inured to the idea of getting more and more seemingly free benefits from the Federal Government, they, too, came in and pleaded with the Senators, "Please restore these cuts."

This is at a time when the system is scarcely in operation, and when we still have over 20 million workers who do not come under the Social Security Act at all—about 22 million workers. Think what the pressure will be when and if you have the entire population in under a social security system. Then everybody will be looking to the Federal Government for one of these handouts, and will come in and say "Oh, don't cut anything; don't cut the benefits; we want more benefits."

We see this right now, in the proposal that President Truman is making. He has said that $25 a month under an old-age pension is too small, people cannot get along on it, so he asks for a 50 percent increase, that is, in the size of the benefits.

Well, you can do that now, when you have a comparatively small number of persons drawing old-age insurance benefits, but what will that mean when you have 22 million persons drawing those benefits, and after we have a few years of that? We are not supposed to think about those things in the beginning.

Now you have referred to this report. I intended to take it up later, but as long as you have referred to it, I have something to say about it right now. The members of the advisory council are certainly distinguished citizens in the community—educators, business men, representatives of labor. That is the type of persons who were selected on this advisory council. But the trouble is, they are all very busy people, they have their own jobs to do.

Mr. Stettinius has been in Europe. I do not doubt that many of these people have been traveling around. I notice that Nelson Cruikshank has traveled quite a great deal. So they are not able to sit down and prepare reports. What has happened is that they have hired a committee staff.

Now, I think the unfortunate thing was that they hired this kind of a staff, which is printed on the last page. I do not know whether they did not know, or did not care. Here is Robert M. Ball, staff director. He used to be with the Social Security Board in the very division that worked on the program planning of the social security program. He heads up this staff, the paid staff.

Leona V. MacKinnon is on loan from the Social Security Board right now. She is listed here as executive assistant. She is one of the top persons at the Social Security Board. I thought that the reorganization of Congress was supposed to get us away from borrowed staffs. And Mrs. MacKinnon, if she is paid and is not merely borrowed, but is also paid—or maybe she is not paid—but at any rate, she is right from the Social Security Board, and responsive to that Board.

Mr. Fedele F. Fauri, loaned by the Library of Congress, has been on the Calhoun staff, which wrote Issues in Social Security in 1946 for the House Ways and Means Committee, and that staff, again, was in favor of expansion of the social security program.

Irving Ladimer also used to be with the Bureau of Old-Age Insurance at the Social Security Board, and I have stated here in my letter that his left-wing activities would bear looking into.

On the staff also is Milton M. Mayer, professional assistant, formerly of the Old-Age and Survivors Insurance Branch, and later in the Federal Housing Administration.

I do not know Helen Livingston, who is listed as research assistant. I have not had time to find out about her as yet.

And then, of course, the actuary, Robert J. Myers, is a very fine actuary. He is in the Social Security Administration at the present time, and is, therefore, restricted, because the Social Security Administration just does not let the facts out. It is important to realize that his superior for many years, William R. Williamson, Government actuary from the time before the Social Security Act was passed, recently resigned from the Social Security Board because he could not bring the facts out. He resigned, just the same as many other persons have left the Board because they could not get the facts out.

He counseled caution time and again while he was with the Board, in regard to this whole program, in regard to the expense, the expansion of benefits, the rising taxes, and the failure in the start to recognize where the thing is likely to go as you get greater and greater pressure, particularly from organized labor, for larger benefits.

I think it is significant that Mr. Williamson is no longer with the Social Security Administration. At the present time he is preparing a report, at his own expense, on this whole situation, in order that Congress and the public may know the facts. His former assistant, R. J. Myers, is a very able actuary, who will, however, have to work within the compulsory framework of that Federal agency, and he will not be able to get the facts out.

I submit that that is not a very good staff to get out important reports like this. And, in addition to that, not only did they have this staff, which was certainly responsive to Social Security, but the report was largely written inside the Social Security Administration itself, not even by this staff, and was fed to the advisory council through Robert M. Ball. It was prepared largely by Albert M. Davis, Chief of the Program Planning Division in Social Security, and by members of his staff. It comes to the advisory council, and more or less by-passes the council, and appears as a committee print from the Finance Committee.

The point is that this is happening in one committee after another. We have seen what has happened here. We have seen it in the Finance Committee, we have seen it in Senator Aiken's committee, the Expenditures Committee, with regard to the lobby in connection with S. 140 and S. 712. It is happening all through Congress, and most of the Senators do not see the total picture, because they are busy with their own committees. So I am glad you brought this up.

Senator Donnell. I notice in the appendix, which gives this statement of the composition of the staff, it is mentioned that the cost estimates of Mr. Robert J. Myers were reviewed by George W. J. Grange, a member of the staff of the Metropolitan Life Insurance Co. Do you know whether or not Mr. Grange has had any Government connections, or not?

Dr. Shearon. No; I do not know, but I will say this, that it has been an unfortunate thing that the large eastern life insurance companies either have not yet seen the whole picture, or perhaps they do not want to see it. As a matter of fact, there are two very well-known actuaries on this advisory council; namely, Mr. M. Albert Linton, president of the Provident Mutual Life Insurance Co., and——

Senator DONNELL. That is from Philadelphia?

Dr. SHEARON. Yes. I thought there was another one. I do not see his name, so I guess that is wrong. I thought there was another one. But, at any rate, here is what is happening with the large life insurance companies, as I see it. In 1935, when the Social Security Act went through, it was regarded in many quarters as a possible threat to the insurance business, and it has not up to this time, proved to be such a threat, for a number of reasons. For one thing, the benefits under Social Security are very, very small, so that they as yet are not competing with private insurance. However, if we get these larger benefits that are being proposed and that labor is asking for, and political parties compete, one with the other, in saying "We will give larger benefits," and the thing zigzags up this way, the insurance companies, I think, may find that there is competition.

Unfortunately, at the present time these large eastern life insurance companies, particularly the Metropolitan and the Prudential, are finding that business is pretty good, and they say people are becoming "more insurance-minded," and so it is perfectly possible, even though a person is to get some very small benefit under Social Security, for the insurance companies to sell either additional life insurance, which would provide funds for the dependents of a deceased person, or additional annuities, so they have a talking point in favor of the Social Security program.

If the life insurance companies really wanted to see the full implications of this, they would realize that in time this movement for Social Security, which, of course, is a part of the over-all movement for state socialism, has a pattern of growth such as it has had in other countries.

We saw it in Germany, and we have seen it in Great Britain, that in time they move toward more and more nationalization, and there are many people who believe the Government should take over various functions in our economic life.

That was a part of the original Bismarck plan, and I think it should not be forgotten that when Bismarck with his economic advisor set up the whole social insurance plan in the eighties, part of the program was to nationalize communications, insurance, and banking, and to set up this social insurance system in order to gain control of the workers.

We should not forget the philosophy back of this, and that philosophy has not changed. It has been taken over by various groups who might not themselves be Socialists or Communists, but who saw a method for gaining control over people and over Government funds. And you get great control if you have control of a $10,000,000,000 fund, and as the people in the population further look to you or your agency for all kinds of benefits, you exercise tremendous control.

Hitler found it very convenient. He found one of his best sources for funds was this nice "kitty" that was lying in wait when he came along, namely, the social insurance funds, and he picked them up and used them. They are a temptation to any party. I am opposed to them on that ground alone, because I think such trust funds are a temptation.

There is a bill before Congress now to build a $9,500,000 building over next to the present Social Security building, and bring the records from Baltimore. And this $9,500,000 building is to be paid for, if they get the bill through, out of the old-age trust fund.

Well, that old-age trust fund has not been collected from the people of this country for putting up buildings in Washington. If you can put up a building for holding records, then if you were to establish a health insurance trust fund, you could put up hospitals and health centers, and many other buildings. You have established the precedent of building buildings and paying for them out of Federal trust funds, although the taxes were collected for some different purpose. So I say to you that enormous trust funds are a constant temptation.

To come back to what we were discussing here, about these insurance companies and the actuaries, you will note that these first recommendations that are coming through for expansion are in the least controversial field, namely, the old-age insurance field. A great many people say that is a good idea, that everybody should have certain old-age insurance benefits, and that in some way the whole thing should be carried through by the Government.

I myself thought that in the beginning. As I have said before, it seemed to be an excellent idea, and, unfortunately, I wrote the economic brief in defense of the Social Security Act. Had I recognized the constitutional implications, I would not have written that brief. I did it in all sincerity, and I now regret it. The brief did truly describe what I found to be the economic condition of our older population. but it was used in the defense of a law that I have come to regard as a very dangerous law.

A good many people do not agree with me. A good many people in Congress will say this is fine and both parties are urging the extension of social security. But I think there should be the greatest consideration given before there is any extension whatsoever, as to where extension will lead. It never goes back. You never get it off the books. There is always more and more and more of it. If you want to look ahead 10, 20, 30 years, which is the time it takes for such a system to mature, you have to consider what you have so often considered, *obsta principiis*. That is the thing I want to urge on you, that we should resist the beginnings, because if we do not resist the beginnings, there is no possibility of resistance afterward, when you have gone too far to retreat.

That is what I think about the whole social insurance plan. It is not likely there will be a law this year, but in this whole movement, the lobby groups are much stronger and more powerful, and much more accepted by large groups of the population, than, say, was the case 10 or 15 years ago, and more of this is being done with Federal funds which are appropriated by the Congress.

Well, we turn to my testimony in the middle of page 26, where I am discussing the rising costs of such a program.

Employees would pay not less than 6 percent; employers 6 percent. The remaining 8, 10, and 12 percent would have to come from deficit financing or from general revenues (presumably from increased income taxes). At this point it is well to recall that although it is only eight short years since a similar omnibus program was started in New Zealand, the system is in a state of financial collapse, and is absorbing 40 percent of all revenues that can be collected. Deficit financing is already being resorted to before all the promised benefits can be put into operation. The New Zealand scheme might have been a blueprint for paradise, but now it looks more like a blueprint for chaos.

I have already inserted the New Zealand Free Medical Benefits. I should like to insert at this point Paradise Unlimited! The Menace of the Police State. It is a description of what is promised by the Socialist state. I should like to have this included in the record in toto. It is a description of the paradise unlimited of the past decade, and the things still promised that will have to come.

Senator DONNELL. It will be included in the record.

(The publication referred to is as follows:)

SOCIALIZED MEDICINE

Physicians and patients enchained by unwarranted governmental regulative interference

[Vol. I. No. 2]

PARADISE UNLIMITED! THE MENACE OF THE POLICE STATE

(By Marjorie Shearon, The Shearon Medical Legislative Service, Washington, D. C.)

THE AUTHOR

Marjorie Shearon, Ph. D., scientist, lecturer, and legislative consultant, was formerly research analyst to the Senate Minority Conference (1945–46) and health consultant to the Senate Committee on Labor and Public Welfare (1947). Prior to that she spent nearly a decade in the executive branch of the Federal Government, 5 years with the Social Security Administration, and 4½ years with the United States Public Health Service.

Prior to her 15 years of public service—Federal, State, and local—she was engaged in scientific research in the biological sciences, her original contributions to science being in the field of evolution. A fellow of the American Association of University Women, past fellow of several national scientific societies, she is a member of Phi Beta Kappa and Sigma Xi.

She is the author of numerous scientific articles and of: Economic Status of the Aged; Health and Disability Legislation in the States: 1939; Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interference; and Federal Propaganda for the Welfare State. She is author of American Medicine and the Political Scene, a weekly analytical news release which she publishes as director of the Shearon Medical Legislative Service.

(Copyright by the Shearon Medical Legislative Service, January 1948.)

QUIETLY WAITING FOR A PARADISE

Britain's inability to achieve a postwar economic revival is ascribed by one observer to the fact her politicians had told the people that socialism meant paradise, and now the people, thinking they no longer needed to work, were "quietly waiting for paradise."

Paradise "is the promise of socialism;" quietly awaiting for its arrival is the menace. Britain listened to the promise. Now she feels the menace. We in the United States are listening. Will we recognize the menace before it is too late?

Many persons in all walks of life are indifferent or resigned. "It's coming; you can't go against trends," they say. Such defeatism is a rationalization, not a reason, for complacency. Admittedly, it is easier to do nothing about the type of government under which one lives than to take a hand in shaping national destiny. It is easier for the scientist to retire to the evanescent security of his ivory tower and for the surgeon to seek sanctuary in his hospital than for either to inquire what he would do if the Federal Government nationalized both the tower and the hospital.

Throughout the world today there is a hue and cry for nationalization. Political, professional, religious, and labor groups which have little else in common unite in calling for more governmental aid. They seem to forget until too late that whenever a national government furnishes financial aid to its constituent units the recipients pay a high price in loss of freedom and in enforced submission to regulative interference.

CRISIS PSYCHOLOGY

During the past dozen years we have become inured to more and more Federal interference with our daily lives. We have succumbed to *crisis psychology.* Real or fancied emergencies are piled upon us like Ossa on Peleon, and we are told that only the Federal Government can save us. One of the interesting developments of crisis or scare psychology is that *emergencies in some miraculous way tend to become permanent conditions.* They are seldom ameliorated by the very programs designed for their improvement. A Federal law is enacted giving the President emergency powers to meet a crisis. A new agency is set up overnight; staff is hired; huge sums of money begin to flow to the agency from the apparently bottomless Treasury of the United States. Directives and rules and regulations are written. States and localities are bombarded with instructions as to what to do and what not to do. Does the emergency disappear under this Federal barrage? Not at all. If anything, it grows worse. Washington officials and staffs, hired on an emergency basis, begin to dig in. Their concern is to put the emergency on a firm and lasting basis, thus guaranteeing perpetuation of their jobs.

EMERGENCE OF THE WELFARE STATE

The beginnings of the welfare or police state in this country are to be found in the vast emergency powers conferred on the late President Roosevelt early in his first term. States, then confronted by the Nation-wide problem of unemployment, appealed to Washington for aid. Billions of dollars flowed from the Federal Treasury to the States through the administrative machinery of the Federal Emergency Relief Administration. The foundation stones of the welfare state were laid in a cement consisting of equal parts of public charity and private demoralization. The country underwent a subtle moral and spiritual degeneration. Before the depression of the early thirties every decent, self-respecting citizen shunned public or private charity. It was considered a disgrace "to be on the county."

But within the past decade relief has become respectable. The dole in one form or another has been sold to the American people as a socially acceptable substitute for personal responsibility and initiative. It has been dispensed to the poor and the not-so-poor under varying names: relief, assistance, parity, or subsidy. But it was always public charity. Students in high school and college accepted their dole from the National Youth Administration. Funds were disbursed gently lest the sensibilities of young persons be offended by the label "recipients of public charity." But those students nonetheless were classified statistically in Washington with all the other "reliefers." Farmers received parity prices and subsidies. The unemployed were given their dole in the form of home relief. Thus, through innumerable governmental programs a large part of the population was indoctrinated in the planned chaos of mass charity.

In time, however, the architects of the welfare state decided they had made a mistake in instituting the dole. What people needed, they said, was made work or, as it might better have been called in many instances, make-believe work. The WPA was set up. Unquestionably it accomplished some good. Ditches were dug, expensively, by people who knew nothing about digging ditches. "Research projects" were carried out by people who knew nothing, and cared less, about research. The national health survey was one such project. The social waste, financially and morally, resulting from WPA was incalculable. The evil of that program lives on; much of the good was interred with its statutory bones when, fortunately, they were laid to rest in 1935.

BIRTH OF SOCIAL SECURITY

FERA and WPA faded out of the picture with the announcement by Harry Hopkins in 1934 that the Federal Government was going out of the relief business But did it go? Not at all.

Immediately thereafter the Committee on Economic Security was appointed by the late President Roosevelt. Outstanding citizens loaned their names and prestige to that committee. But the real work of formulating principles and of drafting legislation was done by a small and designing group that has since risen to great power in the Federal Government. This group drafted the Social Security Act in accordance with principles laid down by the Socialist Dominated International Labor Organization.

In retrospect one realizes that the reports submitted to Congress in 1934 and 1935 were prepared under the direction of social planners who, however well-intentioned, were ill-informed, and of opportunists, who saw in national social insurance unlimited possibilities for personal profit and for attainment of extraordiary power over people.

By 1935 we might reasonably have been expected to have solved our depression problems. The emergency had receded. Presidential emergency powers, one might think, should have been repealed. But no. Opportunists, capitalizing on the situation, urged that a vast system of misnamed "social insurance" be inaugurated.

The Federal Government, instead of going out of the relief business, took steps to nationalize relief and to set it up on a *permanent basis under the Social Security Act of 1935.* The new charity was beguilingly sold to the people as "social security." *Relief* henceforth was to be given either as *public assistance* or as *social insurance. Public assistance* was to be financed from general revenues; *social insurance* from a combination of general revenues and excise taxes. Workers were to receive benefits as a "right." To justify the "right" theory, nues: *social insurance* from a combination of general revenues and excise taxes. which would cover about one-fourth or less of the cost of the ultimate comprehensive social-security program. Employers were to be compelled to pay a tax somewhat in excess of that paid by employees. Approximately one-half the cost of the program was to be financed from general revenues.

Social security was thus designed to be largely a combination of public and private charity—the latter compulsorily provided by employers in the form of excise taxes. Eventually the whole population was to be brought into the scheme and eventually, also, one-fifth to one-fourth of pay rolls would be required to finance these grandiose proposals for mass charity. Because popular resistance developed to a completely federalized social-security plan, it was proposed at the start to federalize old-age and survivors insurance and permanent disability, while permitting the States to operate unemployment insurance and the cash and medical benefits of a compulsory sickness-insurance scheme. *Complete federalization of all parts of national social insurance was, and is, the ultimate goal of the planners.*

If the true objectives of the Social Security Act had been clearly set forth in 1935 and if a referendum vote had then been taken, the bill would probably not have been enacted. Further, if the operations of the Social Security Act were now understood and if the long-range costs and ultimate objectives were divulged, there would, I believe, be a strong demand for repeal of the law.

NEW LEGISLATION FOR BLOODLESS REVOLUTION

The Social Security Act, which hews to both the Socialist and the Communist line and which will inevitably lead to a dictatorship of either the British or Russian type, is the basic law for establishment of a planned economy or welfare state. The concept of the welfare state is of Bismarckian origin. Social-insurance laws came into being as the brain child of two Prussians in search of new sources of revenue to finance an all-powerful state. Bismarck and his economic adviser created the pay-roll tax—possibly the most ingenious tax ever devised. But it is also the most dangerous and most unfair: Dangerous, because it can so easily be abused by governments; unfair, because of its regressive character. The German Government provided the compulsion and interference; labor and management footed the bills. In myriad ways the German people were bound to their central government by the social-insurance laws. Their attitude toward life gradually changed as they accepted compulsion and regimentation, looking more and more to the State, nor only for a pittance of economic benefits but for services in kind, such as free medical care, drugs, and hospitalization.

It is a remarkable thing that such a system as national compulsory insurance should have been so widely and so blindly accepted. Over 30 countries now have social-insurance laws. Once the basic statute is on the books, there seems to be no escape. Whether it would be possible for us to repeal the Social Security Act is debatable, although it is well worth trying. But this much is certain: If a national compulsory sickness-insurance law were added to the present Social Security Act, the country would immediately move forward at an accelerated pace toward dictatorship. *It would be an irreversible step in the wrong direction.*

Whatever may be thought of the operations of the Social Security Act to date, it must be realized that the proposals which Congress will have under consideration during the second session of the Eightieth Congress will depart radically from anything now known to us. There is a clear intent so to change the original law that little of it would remain. The changes proposed are in the direction of more central power. Unfortunately, the executive branch of the Government, aided by certain Members of Congress, has flooded the country with propaganda material in support of the welfare or police state and of a new type of legislation to bring it into being. The taxpayers, all unwittingly, are paying for the promotional activities to have themselves nationalized, whether they desire such nationalization or not. *This is the legislative plan for bloodless revolution.*

Five bills of primary importance for establishment of the welfare state or the super New Deal are now before the Senate. They are S. 712, S. 1320, S. 1679, S. 1714, and S. 1734. The first of these bills, which would elevate the Federal Security Agency to departmental status, is most essential for the over-all scheme. The Federal planners need the prestige of a social insurance department headed by a Cabinet officer in carrying out their plans. Such a Department, under a welfare or social security Secretary, would dominate health, education, and social security. It would control the life of every individual through the earthly paradise of the welfare state. Nay, more! Its influence would reach beyond the grave into a heavenly paradise made more beautiful by Federal regulative control over the dependents of deceased workers.

There is no doubt whatsoever that while we are being told the elevation of the Federal Security Agency would confer no new powers and would simply result in better organization with consequent administrative savings, in reality the whole set-up *would* confer authority, power, and prestige. It is reported the new Federal Security Administrator, Oscar Ewing, was appointed to this position with the promise of the Secretaryship of Welfare, when and if the requisite legislation were enacted. Already internal shifts are taking place in anticipation of the creation of the Cabinet post.

The substantive parts of the new legislation designed to establish the welfare state are comprised in three social insurance bills and in a super maternal and child health bill. The social insurance bills include one (S. 1320) for medical care insurance (the newly coined name for compulsory sickness insurance) one (S. 1734) to provide cash sickness benefits to the temporarily disabled and one (S. 1679) to provide cash sickness benefits to the permanently disabled. The new maternal and child health bill S. 1714, povides benefits under grants-in-aid and would be meshed into the compulsory sickness insurance law, when and if enacted. These Wagner-Murray-Dingell bills dealing with social insurance relate exclusively to *benefits* which are to be conferred. Means of financing the benefits are not indicated but the context implies that a new taxation program calling for expended social security taxes and higher income taxes would be necessary.

ALL-OUT COMPULSION

These bills and other less important ones when taken together provide for the benefits of an all-out national compulsory social security program. Although such a national plan is primarily a scheme for taxation compulsion, and complete Federal control, political and bureaucratic strategy dictate that the legislation conferring benefits shall be discussed first and, if possible, enacted. The taxing program is made the second step. In other words, the bribes are offered first; high taxes and cruel compulsion follow. Benefits and taxes operating simultaneously would go a long way toward assuring establishment of the welfare state.

Such a state is a planned economy based on the assumption that a few leaders have greater wisdom than the population at large. In reality, it is not wisdom they have, but crackpot theories. All too often, like Hitler, they have delusions of grandeur. Many a planner thinks only of placing himself in a key position in the blueprint for paradise. The people, deluded and betrayed, are not permitted to participate in the planning. Unaware of what is contemplated or indifferent to the schemes, they fail to take alarm in time to save themselves from social, political, and economic ruin.

The welfare state in action may be seen in many parts of the world today. Germany set the pattern, Russia followed suit; Great Britain is in the throes of transition to the police state. How alluring is the prospect when the growing promises become cold and barren realities?

Government planning is likely to be based on specious premises. There is the subtle hint or open claim that Washington is the sole repository of superior minds. The cream of public spirited and altruistic citizens, it is said, rises gradually through the several levels of government until at the highest or Federal level there are concentrated the greatest minds, the most unimpeaceable wisdom, and the quintessence of unselfish public service. Finally, it is asserted, neither the people nor the Members of Congress know what is best for the country. They need to be "educated." By whom? The Federal planners themselves!

Despite the fact that the Constitution of the United States calls for three coordinate branches in the Federal Government—the legislative, the executive, and the judicial—some executive departments constantly usurp the functions of the legislative branch by drafting legislation. Further, they prepare for House and Senate Committees "research" documents urging enactment of the very bills they have written. This is what has happened in the case of the successive Wagner-Murray-Dingell bills. Planners in an executive department have not only written those bills but have lobbied for them in the press, on the air, and by overwhelming Congress with tedious reports replete with gobbledygood (i. e., unintelligible "bureaucratese.") Large staffs with calculating machines have worked overtime on statistics "proving" the need for Federal intervention.

The taxpayers' money has been squandered to the tune of millions of dollars by a handful of these all-aspiring Federal officials who are seeking to foist on the American people a system of social insurance and of medical practice wholly foreign to our way of thinking and doing. A steady stream of propaganda has flowed from the Social Security Administration, the United States Public Health Service, the Children's Bureau, and the Farm Security Administration. Anyone writing to the Social Security Administration for informative documents on health needs and medical care programs will receive a kit several inches thick containing various and sundry documents all of which have been printed at the taxpayers' expense and have been mailed under the Government frank. The material is prepared by the Bureau of Research and Statistics which is without a medical staff. This Bureau during 1947 was under investigation by the Harness Subcommittee on Publicity and Propaganda, the Federal Department of Justice, and the Federal Bureau of Investigation. The charge was made that the staff of this Bureau had broken the Federal law on lobbying.

The burden of the arguments advanced by these several Federal agencies is the same, namely, local efforts to improve the Nation's health are inadequate, and voluntary methods to that end are a mere drop in the bucket. Local initiative and ability are minimized, voluntary efforts decried. The answer to all health problems is to be found, according to the officials of these agencies, in the enactment of a national compulsory sickness insurance law which is to be part of the omnibus scheme for compulsion. The over-all plan calls for universal coverage of the entire population, for the increase of existing cash benefits, and for the inauguration of numerous other benefits including free medical and hospital care. The legislation is drafted in conformity with principles originally set forth by Bismarck and later revised from time to time by the International Labor Organization. During the past decade, Social Security officials have played an increasingly important role in shaping the ILO principles and in then drafting our legislation to conform to those principles. Indeed, the first Chairman of the Social Security Board, the late John G. Winant, was a former Director of the Socialist International Labor Organization.

PLANNED ECONOMY GIVEN OFFICIAL SANCTION

A presidential election year is ahead of us. The administration has already announced its legislative program. President Truman in his message to Congress on the State of the Union recommended "a national system of payment for medical care based on well-tried insurance principles" (January 7, 1948). There is talk of including a compulsory "health" insurance plank in the Democratic platform. Both parties are urging extension of old-age insurance to groups not now covered—farm labor, employees in nonprofit organizations, and self-employed workers, such as farmers, owners of small businesses, physicians, dentists, lawyers, writers, and the like. In the fever of a political campaign, when all parties are vying for support, almost anything can happen. By and large, the majority of Republicans are opposed to regimentation, to centralization of power in Washington, and to a super New Deal or welfare state. The Democrats, on the other hand, have accepted the Wagner-Murray-Dingell bills as the legislative vehicles that would implement part of the administration's program.

It is thus evident that the concept of the planned or police state is not simply the starry-eyed dream of a few fanatics or of a handful of individuals with dictatorial ambitions. The *concept* has been accepted as desirable by one major and one minor political party in this country. President Truman looks with favor on a planned economy and has outlined a legislative program to bring it about. Over a decade ago the Communists in the 1936 program of the Communist International flat-footedly declared themselves in favor of national compulsory social insurance. Last year they voiced approval of the Wagner-Murray-Dingell bill, S. 1320. *Legislation to bring about the bloodless revolution of planned chaos is already before the Senate Committee on Labor and Public Welfare.*

What should be done during the second session of the Eightieth Congress? Should we say complacently: "It can't happen here"? Should we take the opposite view, lamenting: "There's nothing we can do to stem the world trend toward dictatorship. It's coming"? Or should we resolve to make the United States truly the last bulwark of liberalism and individualism? I think there is not the slightest reason for pessimism, defeatism, or despair. We should take warning from what has happened and is now happening in Great Britain and in New Zealand. to mention only two countries. Then we should make certain the same things do not happen here.

THE DILEMMA OF PARADISE UNLIMITED

I think few will deny that in the long run the government which adopts comprehensive social insurance is doomed inevitably to wind up with a dictatorship. The transformation does not take place immediately. It took Great Britain 35 years to move from a little compulsion to total compulsion. At present there is talk of crippling the House of Lords in order to silence opposition to the nationalization movement in Britain. Nationalization advances a certain distance within the framework of parliamentary procedures. Then, erosion of those procedures begins.

Labor, headstrong and misinformed, builds up the voting strength and the solidarity necessary to establish the dictatorship of the proletariat. This has happened in Britain, mother of parliaments. Why? Because labor has been sold down the river there, as here, by specious spell-binders who have promised paradise in return for votes.

But who in this world has the power to deliver paradise? It soon becomes apparent that large cash benefits during periods of sickness, unemployment, and permanent disability entail huge outlays and lead to corruption and racketeering. The best modern medical care is expensive, no matter who pays for it—and strangely enough it becomes more expensive to society as a whole when governments rather than individuals pay for the care. Lavish cash benefits and good medical care being extremely expensive in themselves and costly to administer, it is soon discovered that the social-security taxes will not cover the expenses of the system. Indeed, we know that the total program when fully operative will cost 20 to 25 percent of pay rolls. Labor will not tolerate pay-roll taxes of more than 6 or 7 percent. Increasing subsidies are therefore required from general revenues. That means rising income taxes.

But as soon as labor feels the weight of the income tax on top of the social-security tax, a curious thing happens. Labor says: "Why work, if I have to turn back half of what I earn to the Government?" This is the dilemma that Britain faces; this is the dilemma we would face. Although Britain desperately needs more production, workers, tax-ridden and disillusioned, have lost the incentive for maximum effort. Labor is caught between the millstones which they themselves set in motion: one of the stones is the *promise of paradise,* the other *is the cost of paradise.* The promise is the promise of the welfare state, the cost is the inescapable taxation program of such a state. Labor is crushed between the two.

THE PLIGHT OF NEW ZEALAND

What has happened in New Zealand? In 1938 that country enacted a comprehensive social-security law like the Wagner-Murray-Dingell bills, providing for war pensions, eight types of civil cash benefits, and free medical, hospital, maternity, pharmaceutical, related health services. In 1946–47, by the time the health service had been in operation for only 5 years, the total cost of all social-security benefits, including cash and services, had increased to the point where it absorbed 40 percent of the total tax revenue of New Zealand, including social-security taxes plus all other ordinary revenues.

In 1945–46 it was necessary to bail out the collapsing social-security system with a subsidy of 7,000,000 pounds from general revenues—a large amount for a small country with a population about the size of Detroit. The next year the costs jumped again. The subsidy was more than doubled. Instead of taking 7,000,000 pounds from general revenues to finance the social-security system, 18,000,000 pounds were required. At the same time, social-security taxes were increased. In 1945–46 the social-security tax yield was less than one-half the cost of the program. Even at that early stage, before inauguration of all the promised benefits, the runaway costs were turning social security into one comprehensive scheme of costly public charity. The end is not in sight.

While some of the free health services in New Zealand have been moderately successful, the *free medical care benefits are in a chaotic condition.* Five methods of payment are in operation. Expenditures for pharmaceutical benefits have doubled in 5 years. The per capita expenditure for drugs almost equals that for physicians' services. As one surgeon expresses it: "The (social security) fund has to be a bottomless pit." Hospitals are crowded with patients not in genuine need of hospitalization. Physicians, compelled to increase the number of their patients if they would make a living under the Government fee scale of 87 cents for an office visit or $1.50 a year per head under the capitation system, find that the *quantity*, not the *quality*, of the services is what counts. Research suffers. Medical education deteriorates. This may be the Government's idea of paradise, but neither the people nor the professions so regard the New Zealand blueprint.

RESIST NOW!

I have touched briefly on some of the social and fiscal problems confronting Britain and New Zealand as a result of their nationalization movements. These two countries serve as clear illustrations of nationalization. They should with equal clarity serve as potent deterrents. The time is at hand to ask ourselves whether we have not already gone too far down the road toward dictatorship in accepting the Social Security Act, the Railroad Retirement and Unemployment Insurance Acts, and the Crosser amendments to the latter. If we fail to resist the trend toward dictatorship *now*, can we do so successfully at a later date after the vested interests of the Government and of the prospective beneficiaries have become more deeply intrenched?

Now, is the time to ask if we can indulge in a little planned chaos without ultimately succumbing to the completely planned and universally compulsory welfare state. *Now* is the time to guard jealously our Constitution, our laws, our courts, and all those things which we know as the American way of life. We need to resist vigorously the vociferous minorities in our midst who are working against the best interests of the people as a whole. *The members of all professions have the responsibility to become fully informed about what is going on in Washington.* They have the further responsibility to present the facts and the issues at stake to the citizens of every community and to join forces with other groups which are alert to the menace of the police state. Finally, they have an inescapable duty to carry this fight to the polls. Since legislation for nationalization is a political bait it can be defeated only by concerted and informed political resistance. If men and women of vision do not assume leadership, we are in great and immediate danger of being induced to surrender our birthright to an all-powerful State in return for the privilege of quietly and lazily awaiting the promised paradise of nationalization.

Dr. SHEARON. What would the free health and medical programs proposed in S. 1320 cost? I will not attempt to split hairs, but I believe an estimate of $50 per capita would be reasonable for medical care, hospitalization, dental care, and related services.

I might say that since writing that, I have received a very exhaustive book from New York. I failed to bring it here this morning, but I should like to include at this point a table of cost estimates which were worked out in New York in connection with a study they were making of what it would cost to put into effect a State law for medical care and sickness benefits.

Senator **Donnell**. The table will be included when furnished.

(Dr. Shearon's introduction and table as described were submitted as follows:)

The National Industrial Conference Board, Inc., in its valuable report on compulsory sickness compensation for New York State, 1947, page 158, gives a number of estimates of costs for medical-care benefits under several proposed bills in New York State and for complete benefits. The estimate of $71.59 per capita, or $78.75, including cost of administration, is of the order of magnitude for the benefits proposed in the Wagner-Murray-Dingell, S. 1320. The total cost for a population of 143 million persons would be over $11,000,000,000 for complete medical and hospital care, drugs, appliances, and nursing and dental care, provided by the Government.

Estimated per capita cost of benefits under Farbstein, Ives, and Austin bills, and for complete benefits, with estimated total cost of complete benefits

[Dollars per person per year]

Benefits	Farbstein	Ives	Austin	Complete	Total complete (in millions)
Physicians and laboratory	19.02	19.02	19.02	20.65	283.9
Hospital	11.58	11.24	12.06	[1] 12.19	224.6
Drugs		[2] 2.00	[2] 3.00	6.00	82.5
Appliances			[2] 2.50	2.50	34.4
Nurses	.50		1.25	1.25	17.2
Dentists	15.00	4.70	29.00	29.00	398.8
	[3] 46.10	36.96	66.83	71.59	1,041.4

[1] If mental and tubercular cases are covered, add $4.40. Allowance for them has been made in the total column.

[2] Represent the maximum additional benefits.

[3] Incomplete because no item has been included for appliances and the nursing benefit is by no means accurate.

Dr. **Shearon**. I might say I have used this very low figure of $50 per capita for medical care and so on. The estimates run as high as $78 to $100 and some estimates have gone even higher than that. So $50 is really a very small amount, and that would be $7,000,000,000 a year.

The figure Mr. Falk mentioned in his paper in 1944, not counting the administrative cost of $700,000,000 a year, and likewise not counting the cost of capital outlay for construction of hospitals, health centers, research centers, medical schools, and other educational facilities was much smaller.

Nor would those sums, huge as they are, allow anything for the expansion of public health services. Within 5 years after the enactment of such a law, we might well be obliged to find some $10,000,000,000 a year for the national health program alone, not taking into account the cost of all the cash benefits promised under the remaining security legislation. If the program were sound and desirable, if similar proposals had proved effective elsewhere and had brought about great improvements in national health, then I think we should make every effort to see if such huge tax funds could be raised without placing an undue burden on the people.

Has any other country something better to offer than what the United States has? But what proof is there that if we destroy the present system in American medicine, if we thus burden ourselves to the breaking point with far heavier taxes than we now bear, and if we bow to the heavy hand of bureaucratic control—what proof, I ask, do we have that the rewards we might receive would be worth the price we would have paid? Repeatedly this subcommitte has been told that a system of national compulsory medical care insurance will go a long way toward solving the problems of the distribution of medical care. Repeatedly you have been told that physicians will be distributed more equitably, that rural areas will be better served, and that economically depressed areas will attract more doctors. Repeatedly you have been told that the "shocking health conditions" in the United States will be ameliorated if you will but enact S. 1320 or some similar piece of compulsory legislation.

Senator DONNELL. Doctor, by the term "shocking health conditions" are you conceding here that there are shocking health conditions in the United States?

Dr. SHEARON. No. I should have put that in quotation marks.

Senator DONNELL. You do not agree with that statement?

Dr. SHEARON. Not at all. I should have put that in quotation marks. I ask that they be now inserted before and after the words "shocking health conditions."

Senator DONNELL. That will be done by the reporter.

Dr. SHEARON. But has any witness come forward to give you an illustration of a country which has tried compulsory insurance on such a vast scale with success? Do we wish to follow in the footsteps of Germany or Great Britain, which tried the scheme on a modest scale, or of Russia, which went all the way to communism? Have we any reason to envy the health conditions of the people in those countries? Had we any reason to envy those conditions before the war? Statistics have been presented to you and have been widely circulated that make it appear the United States makes a poor showing in regard to health indices.

Without going into details, I may say that much of the material presented to you by Government officials has been purposely misleading and has been given to you for the purpose of selling legislation that would confer vast powers on the persons who drafted the bills. For instance, there have been given to you and to the public tables of comparative mortality rates, so presented as to make the United States appear at a disadvantage. In general, I may say that international vital statistics are not recorded or compiled on comparable bases from country to country. Whenever statistics are used they should be presented with entire candor and with explanations as to their shortcomings. Unfortunately such candor has been lacking in much of the material presented to this subcommittee by Government witnesses. You have heard the testimony of Dr. Maurice H. Friedman in which the reliability of reports emanating from the Bureau of Research and Statistics, Social Security Administration, has been successfully challenged. These reports have also been challenged by Dr. Elizabeth W. Wilson in her recent volume on Compulsory Health Insurance.

I might add that in the volume that has just come out from the Brookings Institution, of course, the figures are challenged extensively.

The credibility of the top Federal officials in that Bureau has been questioned justifiably. We must therefore proceed with caution in coming to any conclusions on national health if they are based on reports from the Social Security Administration.

I might add about the various vital statistics reports we have had, just one or two illustrations. For instance, mortality and other statistics given compare generally unfavorably, say, with New Zealand and the small Scandinavian countries.

It must be obvious, even to a person who does not specialize in statistics, that there is no comparability between a little country like New Zealand and a large country like the United States. To compare their statistics in regard to health, we must remember that New Zealand is quite a different country from our country. They have a population of about 1.6 million persons. They have a pastoral population. Their living conditions are not crowded. They have no large industrial centers. There is nothing comparable in the way in which they live, with our way of living in our crowded cities. In addition to that, they have a native population of Maoris, and the statistics in regard to their health are always omitted by these government people and by Carl Malmberg. They give statistics on the white population and then compare them with the statistics on the total population in the United States.

The fair thing to do in giving such statistics, assuming that they could be or are collected on a comparable basis, would be to compare some smal larea, perhaps a city or some rural community in the United States, with the population in New Zealand of a comparable size.

In other words, an honest statistician would try to get comparable conditions, social and economic conditions for two populations of the same size, and compare 1.6 million persons in the United States, where he could find conditions as nearly as possible like those in New Zealand, with the same population in New Zealand. That would be giving fair and honest statistics. When I say that many of the statistics that have been put out by the Social Security Board have been crooked statistics, I mean that while the figures may in themselves be correct, that you may have so many deaths and so many children die at 1 year of age, something of that sort—the interpretation is not honest, and the statistics are not given on a comparable basis with the United States.

The same thing holds true in the Scandinavian countries. Therefore, statisticians as a rule do not like to make any broad generalizations about what you can conclude as to health conditions in one country as compared to those in another country, and, particularly, they do not compare very small countries with very large countries.

That should be borne in mind, because over and over again we have had these derogatory statements made about the United States. Now it is perfectly true that in some parts of the United States, in certain rural areas and in certain congested areas in cities, the health conditions are poor, there is overcrowding, there is poor nutrition. A great many factors enter into the picture besides the factor of whether or not the people have a doctor.

I think it would probably be generally agreed that good nutrition is of more basic and fundamental importance than whether or not you have a doctor. I think doctors themselves would say that. In fact, I think I saw it recently in a statement about a nutrition report. That has been brought out very clearly.

I would say the statistics we have been getting are just not fairly presented and their interpretations are certainly devious, and purposely so. The worst part of it is that in many instances the people who present these statistics are well informed. It is not ignorance, it is not lack of availability of statistics. They have statistical staffs, very large statistical staffs, in the Social Security Administration. There are some very well qualified persons there, and when they withhold information from Congress, they do it purposely, and that is the thing we should bear in mind.

Now I just want to summarize a few things about the European experience. Insofar as European and other foreign experience with compulsory sickness insurance is concerned we may conclude at least this much:

1. The coverage has generally been for a small part of the population in the beginning and has gradually increased over several decades until complete or nearly complete coverage has been attained.

I have pointed this out repeatedly, that at the present time the movement now is to get everybody into the social security system in one of the sets of benefits, for instance, old-age insurance. After you get the whole population in and get everybody paying taxes, you then add on additional benefits and increase the size of benefits. But the main thing that the persons who are working on this nationalization movement are working for now, is to get everybody into the system and to do it as fast as possible.

Thus in Germany Bismarck's sickness insurance scheme was limited to 10 percent of the population, the very poorest people who were in danger of becoming public charges. After 50 years about two-thirds of the population was receiving Government insurance medical care. It took that long, 50 years. Great Britain started with limited coverage and gradually worked up to 40 percent of the population during a period of about 35 years. This year it is planned to nationalize medicine in Great Britain. As of the first of July, it is planned to compel everyone to accept public medicine, to compel all physicians to become servants of the state.

Russia started a national health insurance scheme under the Czars in 1911. The Soviet Government accepted the Czarist scheme and today the entire population is subject to a system of state medicine. All doctors are servants of the state; there is virtually no private practice. In New Zealand the attempt was made to socialize medicine overnight and to bring in the whole population at one time. It is 8 years since the law was passed and the system is still in a chaotic condition. The point is, that the trend is from a little compulsion to total compulsion; from health insurance with some state medicine to a condition of complete state medicine.

2. The number of days of illness has increased and the costs of the system have risen in countries which have inaugurated compulsory government plans for distribution of medical care. The reasons for this rise are largely psychological and economic. I have referred here to a volume I have inserted in the record.

Senator DONNELL. That is the "Paradise Unlimited"?

Dr. SHEARON. Yes, where I give a discussion of the question. This whole thing was so lengthy, I felt I could not take time to go into the whole thing in detail, so I have inserted these various exhibits, which will give the information.

3. Taxes have been put at a low figure at the start in order to sell the idea to labor, to the public at large, and to legislators. As the costs rise one of several things happens: (1) taxes are increased to

meet the deficit, (2) benefits are limited, or (3) rates of payment to professional personnel are cut. The limiting of benefits tends to a downward leveling of health and medical services. As rates of pay are cut there is the downward leveling of professional incomes and resultant discouragement among practitioners who are inadequately rewarded for professional services.

I know that it has been proposed, even, that physicians take on as many as 4,000 patients in order to get enough out of a system that does not pay adequately, and you can readily see that when all of the money has to come out of a fund in Washington, a fund which varies according to the taxes that can be raised from pay rolls, that you are bound to have deficits arising at a time when pay rolls are down, and when the demand for health and medical services may go up. You have the choice at that time of increasing the general revenue, the income taxes, and paying them into the health fund, or limiting the benefits. That is not very good for the health of the people, and I do not believe that has been the promise to the people as to the way it would work, when you would not yourself control the money you are going to spend for a doctor.

Of course, I might point out that in President Truman's recommendations, which he just made on May 24th, he has said already, as early in the game as this, that in order to provide for some of these extra benefits that are being promised, for instance, larger benefits for old age, he wants to increase the present taxes from the wage level of $3,000—in other words, employees are now taxed 1 percent on $3,000—he wants to raise that wage level up to $4,800, and, also, to bring in other persons, like the self-employed, the lawyers, dentists, doctors, and so forth, who are to be taxed. Many of them will never get any benefit out of the system at all. It is admitted that many people pay taxes into the social security system who will never get benefits, but they pay them so that these benefits may be given to other people.

While I am discussing this, I would like to say that I think one of the things that has not been seen is that you will be compelled to put into your budget—each one of you is going to pay these taxes—that you will be compelled to include in your budget your social security tax for old age, unemployment, medical care and sick benefits, and so on. Many of these things you do not now budget for. You do not set up a fund for this, that, and the other thing in your own budget. And when you are compelled to pay out this 6 percent as an employee—and it would be 9 percent for a lawyer, the self-employed would have to pay more than employees, they would pay 9 percent of their earnings, up to earnings of $4,200—it is for something you do not necessarily budget for now, except that you may have savings you put aside for a rainy day, to cover a time when you are ill, or something like that. But you will be compelled to do a tremendous amount of budgeting, not only for your own needs, but for the needs of other people in the population. And that is being brought out, that these taxes are being put on, not to pay benefits to the people who are paying the taxes, but to pay benefits to other people who will receive those benefits without paying for them.

It is a very large scheme for redistribution of income, but doing it in a different way, and, as I think, a less satisfactory way than through income taxes. In other words, you put a flat percentage charge on employees' incomes. There is not the same decrease that you get for low income groups under the present income tax payments, where the low paid groups either do not pay at all—millions of them do not pay at all—or they pay a very small amount under a graduated tax. But the social security tax works a great inequity on the person of low income, because it would take in time 6 percent of the income of all persons making $1,800, $2,500, or $3,000 a year.

These tax provisions are things which people just have not been looking at at all. They involve a compulsory system of budgeting for items that you may not need to do any budgeting for in your own family. Suppose you are in good health, and you do not spend much on medical care. You might not want to put aside, say, 1½ percent of your income to give to the Federal Government for medical care insurance; and 1 percent for your cash sickness benefits. Of course you would not do that if you were a lawyer, because you would not be charged for that. But I think that this enforced budgeting to turn the money over to some agency of the Government after you budget it, and perhaps do not get any benefit yourself, but have somebody else get the benefit, is a very clever scheme, and I do not believe many persons have seen through it.

4. Medical care insurance, i. e., compulsory sickness insurance, has been costly to the insured population. The savings spoken of in advance do not materialize. That is very important. We are told most glibly by the persons planning this compulsory scheme that they are going to have this, that, and the other savings. As a matter of fact, such savings have not materialized in other countries, and we find that the expenses of policing the system, the tremendous amount of paper work that develops in keeping tab on physicians, nurses, dentists, pharmacists, and all of the persons who deliver services and materials, together with the job of policing the patients, cost a tremendous amount of money. And, in addition to those administrative functions that are absolutely essential for carrying on a Federal program, before very long, in addition to those things, you have all the other research boondoggles that can be devised in governmental agencies, that do not have to do with the operations of the program, but that are thought up to keep staffs busy and to justify requests to Congress for larger and larger sums. I think that that will be found to be true in each one of the operating programs in the Social Security Administration at the present time.

They have 299 persons engaged on research, and the number of utterly foolish projects that are devised just to keep people busy, and which have nothing to do with the operations of the program, is simply astounding. It would pay Congress to dig deeply into that particular phase of a compulsory insurance scheme.

So the savings that are promised in advance simply do not materialize, because you set up a whole new set of expenditures that have not even been in the picture before, and do not have anything to do with the delivery of services as a whole, a nonmedical set of expenses. In addition, of course, there are many medical administrative persons brought into the picture, because of course you must have the medical policemen to check up on the physicians, and to say whether or not they are doing the right thing.

Senator DONNELL. Who will check on the policemen?

Dr. SHEARON. That is the great question, isn't it? It sort of grows.

Doctors are not more equitably distributed. We have heard so much in this committee about the inequitable distribution of physicians. That is perfectly true. There are not as many physicians out in the "sticks" as there are in the large cities. You and I are living in a large city, and we might not want to go to some little place in the country where there is nothing to attract us, no interesting job, no other professional people, where incomes are low, and there are no places for the members of one's family to have any type of social life, and so on. It is perfectly true that professional persons, not only doctors, but lawyers, and other types of professional persons, are not equitably distributed.

If doctors are ever to be induced to go to rural areas, the inducements that might be offered, such as better hospital facilities and more adequate incomes, can probably better be provided outside of a compulsory insurance system than within it. But rural practice will not necessarily be made attractive merely by providing hospitals and better incomes. Many communities have little to offer to professional men and their families, as I have stated before. Proposals for the solution of this problem have been made, but they do not require national compulsion.

As I have stated, there are many proposals under consideration now to induce doctors to go into rural communities, but in many instances it will be found far cheaper and far more desirable to bring the patient to the doctor instead of taking the doctor into sparsely populated communities. Now, with good roads, airplanes, and facilities for taking a seriously injured person very quickly to a large hospital, it will be very much better to have such facilities in our larger communities, where they can be associated with medical skill and with medical science, where patients can get the very best of attention, rather than attempt to build large numbers of facilities all over the country in small communities.

And, as I say, that is not the whole thing to be considered in attempting to attract physicians to sparsely populated communities. Physicians in that respect, I think, are no different from anyone else, particularly professional people. They want to have opportunities for their intellectual life, their social life, and for their families. Putting in a program of national compulsory insurance will not effect any better distribution, unless, and this is quite possible, the Federal Government says to a doctor, go here, or go there, as has been proposed in Great Britain.

6. Methods of payment have profoundly affected the quality of medical services. New Zealand is a recent example of the effect of methods of payment on the quality of health and medical services. I refer you to my exhibit on New Zealand's Free Medical Services, and also to the book which I have introduced. For further discussion see Sulzbach. At the back of the paper I have referred to that.

Senator DONNELL. "Sulzbach, Walter, German Experience With Social Insurance."

Dr. SHEARON. I gave a copy to each Senator. It is probably in your file. That is a recent book, and a very excellent book, by a man who knows the German system, and who explains many of these matters that have not been brought out very clearly.

7. Medical services have not improved under compulsory sickness insurance. I wish to introduce here another publication on "Bureaucratic Control of Medicine," which I should like to have included in the record in toto. This, again, covers some of these matters, so I will not have to go into details here for the committee.

Senator DONNELL. It may be incorporated at this point.

(The publication referred to is as follows:)

SOCIALIZED MEDICINE

Physicians and patients enchained by unwarranted governmental regulative interference

[Vol. I. No. 3]

BUREAUCRATIC CONTROL OF MEDICINE

(By Marjorie Shearon, The Shearon Medical Legislative Service, Washington, D. C.)

THE AUTHOR

Marjorie Shearon, Ph. D., scientist, lecturer, and legislative consultant, was formerly research analyst to the Senate minority conference (1945–46) and health consultant to the Senate Committee on Labor and Public Welfare (1947). Prior to that she spent nearly a decade in the executive branch of the Federal Government, 5 years with the Social Security Administration, and 4 years with the United States Public Health Service.

Prior to her 15 years of public service—Federal, State, and local—she was engaged in scientific research in the biological sciences, her original contributions to science being in the field of evolution. A fellow of the American Association of University Women, past fellow of several national scientific societies, she is a member of Phi Beta Kappa and Sigma Xi.

She is the author of numerous scientific articles and of Economic Status of the Aged; Health and Disability Legislation in the States: 1939; Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interference; Federal Propaganda for the Welfare State; and Paradise Unlimited—the Menace of the Police State. She is author of American Medicine and the Political Scene, a weekly analytical news release which she publishes as director of the Shearon Medical Legislative Service.

(Copyright by the Shearon Medical Legislative Service, January 1948.)

WHAT IS OFFERED IN LIEU OF WHAT WE HAVE?

Probably few persons would challenge the statement that the United States today stands preeminent in the field of medicine. Standards of medical education, outstanding contributions in medical research, and easy availability of health and medical services to the major portion of the population place the United States in a unique position among the countries of the earth. We have more physicians per unit of population than any other country in the world. Our health indexes for comparable population units are not surpassed by those of any other country.

In the face of these facts, how can we account for the persistent efforts which are being made to destroy the American system of medical education, medical research, and medical practice? What justification can be found for the propaganda which has flooded the country, especially during the past decade, in support of a revolutionary upheaval in the entire system of American medicine? What is offered in lieu of what we have?

These questions are not difficult to answer. Justification for this proposed revolution is found in the purposely misleading research documents which are disseminated by governmental and nongovernmental lobbies with a view to shaping the opinions of Congress and of the public in favor of a medical system controlled and financed by the Federal Government. We are asked to exchange freedom of action by patients, physicians, and institutions for the despotism of bureaucracy. We are asked to adopt an Old World system of government medicine which is not known to have succeeded anywhere, but which nonetheless is loudly acclaimed by those who would gain power were such a system established in this country.

POLITICAL AND BUREAUCRATIC MEDICINE NOT SYNONYMOUS

How has such a situation come about? Are the politicians to blame? Not directly, for they are not the planners and prime movers. I believe the danger lies not in political, but in bureaucratic medicine. The two are not synonymous. Neither the President nor any Member of Congress has the time or the professional competence to draft the complex legislation dealing with Government control of medicine. A politician could not, if he would, write rules and regulations for administration of a comprehensive national health program. It was not politicians who initiated the lobby for nationalization of medicine. It was not politicians who drafted the blueprint. Instead, it was a small group of Federal officials who made the plans, wrote the legislation, supervised the lobbies, issued the publicity, and made elaborate studies of the rules and regulations in foreign countries preparatory to drafting similar administrative regulations for the United States.

There are those who, oblivious of the signs of the times or perhaps secretly in favor of them, will tell you that all is well and that there is nothing to fear. The nationalizers encourage this feeling of complacency even as Hitler duped Chamberlain. It is ever easier to be unalarmed than it is to face painful realities requiring action. Enactment of Federal legislation for national compulsory sickness insurance is an ever-increasing threat. Within the Government at Washington there is a well-developed propaganda organization to promote enactment of legislation for compulsory sickness insurance. Private lobbies are active. Nor should we forget that compulsory legislation has been enacted in other countries not because of popular demand or even with the consent of the people, but as a result of the activities of small, well-organized groups, all of which are following the same international blueprint.

We have before us the example of Great Britain where, since enactment of the national social insurance law of 1911, medicine has felt increasingly the heavy hand of bureaucratic control. It takes several decades for the destructive processes inherent in national social insurance fully to be felt. It takes more than one generation of physicians reared in an environment of regulative interference for the profession to feel the complete effect of Government domination of medical education, research, and practice.

BRITAIN'S NEW DESPOTISM

Some years ago the Lord Chief Justice of England wrote a book entitled "The New Despotism." He described the administrative lawlessness visible throughout the executive departments in Great Britain. Noting that it was the officials in the Government departments who initiated the legislation by which arbitrary powers were conferred upon them, he said:

"Arbitrary power is certain in the long run to become tyranny, and there is danger, if the so-called method of administrative 'law,' which is essentially lawlessness, is greatly extended, of the loss of all those hardly won liberties which it has taken centuries to establish."[1]

In discussing the mischiefs of bureaucracy, he pointed out that the excellence of the Civil Service might actually work against the public interest to a greater degree than a bureaucracy of less able experts. For, as the Lord Chief Justice pointed out, "* * * it may perhaps be well remember that high capacity and ardent zeal need to be more carefully watched than when they appear to have entered with all their might, upon a wrong road. It does not take a horticulturist to perceive that, if a tree is bearing bad fruit, the more vigorously it yields, the greater will be the harvest of mischief."

Lord Hewart warned that "if there were any great extension of the system of giving uncontrolled and arbitrary powers to public officials it is as certain as that night follows day that corruption must creep in. We shall then be cursed with the corrupt bureaucrat. The bureaucratic despot we already have."

To illustrate his point, Lord Hewart said: "The treatment of the panel doctors under the National Health Insurance Acts is pure despotism. The doctors are liable, at the mere discretion of the official who acts for the Minister of Health, to be ruined professionally by being struck off the panel, or, as a lesser punishment, to be fined to an arbitrary extent. In one instance, a fine of £1,000 was imposed on two doctors who carried on business in partnership. 'Excessive prescribing,' an offense wholly unknown to the law, which consists in prescribing for the patient medicines that are either too expensive in quality or too liberal in quantity, is one of the things for which a doctor may be penalized. One might think that, for a person who is bound by law to insure and pay contributions under the [Health Insurance] Acts, the best medicine ought to be prescribed in illness. One might also wonder whether, in this matter, the interests of the patients are taken into consideration at all."[2]

---

[1] Lord Hewart of Bury, The New Despotism, New York, 1929, p. 52.
[2] Ibid., p. 50.

It has been well pointed out by an Australian that "there is no penalty for under-prescribing, no penalty for under-certification, no penalty for under-treatment—a cynical disregard of the welfare of the patient, which is further illustration of the fact that the Government's interest in the whole matter is purely financial."[3]

RULES AND REGULATIONS ARE BASIC EVIL OF GOVERNMENT MEDICINE

The rules and regulations for compulsory sickness benefits are well established, and if a Wagner-Murray-Dingell bill were to be enacted in this country I surmise that the administrative regulations would not deviate to any great extent from those which have been developed in other countries. The problems of health insurance administration have been wrestled with for upward of 65 years in different parts of the world. Human ingenuity in over 30 countries has had the fullest opportunity to discover workable methods, if there are any. No country has even approached a satisfactory solution to the problems. Administration becomes more cumbersome each year. Sickness and the vagaries of human nature refuse to be neatly pigeonholed. By the time the British scheme had been in operation 20 years, there were over 2,000 regulations in force to plague physician and patient alike. Before three decades had passed it required a volume of nearly 1,300 pages in length to cover the basic health insurance laws and amendments thereto, the Government rules and regulations, and the official interpretations thereof.[4]

It is obvious that if the Federal Government is to pay for medical care, for hospital services, for prescriptions, for nursing, dental, X-ray, laboratory, and a host of other services, the Government must define the services. If it attempts to pay a physician on a fee-for-service basis, it must pay specified amounts for a given number of minutes of a physician's time and must allow for overtime. The administrative difficulties of fee-for-service are so insuperable that no person familiar with them believes the Government could or would operate on that basis. Indeed, one of the leading advocates of compulsory sickness insurance, Dr. Ernst P. Boas, chairman of the Physicians Forum, Inc., has frankly stated:

"Insurance guaranteeing complete medical coverage cannot be set up except at a prohibitive cost, if the fee-for-service principle is retained."[5]

If the capitation system is adopted, the physician holds the bag. The Government makes the promises; the physicians carry them out. However unreasonable the promises may be, the physician must somehow contrive to fulfill them if he agrees to become an insurance practitioner. He must cantract to accept some nominal amount, say $5, $6, or $7 a year (it is $1.50 in New Zealand, $2.25 in Great Britain) for each person on his list. He must give to those patients all the services they demand and the Government promises. In other relationships in life when a contract is made both contractors know in advance what is being agreed to. But when a doctor makes a contract with the Government under compulsory sickness insurance he is making a blind date with fate. The Government can and does change the rules of the game whenever it sees fit. It can re-define services; it can lower capitation rates; it can tell a physician when he may or may not send a patient to a hospital; it can call a physician on the carpet for "overprescribing": it can issue punitive regulations and can fine physicians for infringements of the endless regulations which must be issued in the vain attempt to regularize medical practice.

The administrative patterns of bureaucratic medicine follow the same general plan in all countries. Federal officials in Washington have for years been studying the classic volumes on administration published by the International Labor Organization and by the governments of foreign countries. The basic text is the volume entitled "Economical Administration of Health Insurance Benefits" which was published at Geneva by the ILO in 1938. The first part is devoted to a lengthy discussion of *The Principle of Economy in Administration*, the second to *The Principle of Economy in National Laws and Regulations*, the two together requiring some 300 pages.[6] The volume is replete with statements and statutory provisions designed to curb the freedom of action of physicians and patients. *Economy of Administration* is the watchword of insurance medical practice. You will note the frequent inclusion of the "economy" principle in the W-M-D bills.

---

[3] Byrne, Charles, Proposals for the Future of Medical Practice, Melbourne, 1943, p. 115.

[4] Lesser, Henry, The Law of National Health Insurance, London, 1939, 1,281 pp.

[5] Boas, Ernst P., Why Do We Need Health Insurance? No date, p. 13.

[6] Economical Administration of Health Insurance Benefits, ILO, Geneva, 1938, 332 pp., p. 197.

The insurance practitioner at every turn must say to himself: "Which of these two procedures or drugs is the cheaper; which will save the insurance funds" instead of saying: "Which is better; which will save the patient." He must be ever mindful of the funds, ever subservient to the Federal insurance inspector, ever on the defensive to justify his professional decisions and to defend himself against charges of real or fancied infringements of Government regulations.

PRINCIPLE OF ECONOMY IN GOVERNMENT MEDICINE

To illustrate a general principle regarding doctor-patient relationship under government insurance practice, I quote from the ILO text to which I just referred. In the chapter devoted to "The Application of the Principle of Economy to Diagnosis," there appears this statement:

"If a private practitioner recommends some necessary form of a diagnosis to his patient and the patient declines to have it, either because it is physically repugnant to him or because he finds it too expensive, the doctor can, if his professional conscience permits, console himself with the thought that he has given the best possible advice. The insurance practitioner, on the other hand, must urge the insured person to follow his advice as regards diagnosis. If the patient still objects, the doctor must consult the medical adviser of the insurance institution or send his patient to a hospital, because otherwise the necessary measures for a diagnosis, prevention, or cure will be applied without sufficient preparation and will therefore not be truly economical." [7]

In carrying out this principle of economy, the law in Germany required that "the attending practitioner must prove the necessity of hospital treatment in writing." "Economical treatment" was defined in the law and the practitioner was adjured in carrying out his duties to "save the fund expense as far as the nature of his services permits." The Government inspectors and tribunals were the final arbiters as to whether or not a physician had been sufficiently solicitous of the insurance funds.

Since an insurance practitioner is liable for losses incurred by the insurance fund if he fails to compel the patient to follow his advice, and since he may be hailed before a tribunal to defend subsequent demands on the insurance fund in the event that a headstrong patient adopts a course which later leads to expensive treatment costs, the practitioner in Germany is authorized by law to send a patient to the hospital without the patient's consent. The law states: "The consent of the sickness fund must be obtained before admission to hospital except in urgent cases." The patient's consent is not required if, *inter alia*, "the patient repeatedly disregards the doctor's instructions or the rules for the conduct of patients." [8]

With respect to prescribing by insurance practitioners, we find these principles and rules enunciated for the German scheme:

"The sickness fund has to prepare data enabling the Insurance Practitioners Association to control excessive prescribing by means of the standard cost of prescribing. For this purpose the cost of prescriptions per case is calculated for groups of practitioners and for each individual practitioner.

"The IPA also checks the cost of prescribing medicines and minor appliances. If this cost exceeds the so-called standard cost of prescribing, the doctor can be made liable for part of the excess.

"The standard cost of prescribing is fixed in a national agreement between the IPA and the central federations of sickness funds of March 18, 1938, and represents the average amount per case treated, which as a rule is not exceeded in the economical prescription of drugs and appliances." [9]

POLICING OF FEDERAL MEDICAL CARE SYSTEM

Under insurance practice the Federal policing of the system would be accomplished through a special medical supervisory department under the direction of a chief medical referee, if the usual pattern were followed. In Germany there was one full-time medical referee for every 25,000 insured persons. In the United States that would mean an army of 5,600 Federal medical referees to police the system. In each district office there would be supervisory committees and subcommittees for special questions. In addition, there are pricing bureaus to check individual prescriptions. There would be about 700 pricing bureaus in the United States, and these would cooperate with the accounting officers of the Insurance Practitioners Association.

---

[7] Ibid., p. 38.

[8] Ibid., p. 197.

[9] Ibid., pp. 208, 209.

In policing the insurance system to assure that all practitioners are abiding by the economy principle, which is the *sine quo non* of insurance practice, the IPA accounting office keeps statistics on the number of cases treated by each general practitioner and specialist and on the number and cost of prescriptions. When the insurance fund files a claim against a physician who is suspected of overprescribing, "the practitioner's average case expenditure for the quarter of the year under review" is computed. If this expenditure is in excess of the standard cost of prescribing, a claim for damages is submitted. "The standard cost of prescribing per case treated is fixed in the national agreement for the whole country." [10]

I have given these detailed illustrations to show a few of the ways in which American medicine would come under bureaucratic control if compulsory sickness-insurance regulations were enacted. The real threat lies not so much in the basic law but in the subsequent rules and regulations which, while not enacted by Congress, would yet have the force of law. This would be the new despotism of which you have had a foretaste in the regulations issued by the Children's Bureau, the Social Security Administration, the Federal Security Agency, and the Public Health Service. However, the existing grants-in-aid programs of these agencies do not begin to carry such administrative powers as does a compulsory social-insurance program.

SOCIAL SECURITY ADMINISTRATION IS PROPAGANDA AGENCY

If anyone in this country thinks there is little likelihood of enactment of Federal compulsory sickness-insurance legislation, it would be well for such an individual to look at the record of the past 10 years. Within the framework of the Social Security Administration there has been created in the Bureau of Research and Statistics a Division of Health and Disability Studies. Such compulsory legislation as the health and medical titles of the W-M-D bills has been written in that Bureau. The amount of propaganda for compulsion that has emanated from the Federal Security Agency is staggering. "Research" memoranda, speeches, reports, radio addresses, and statistics are prepared in and circulated by the Bureau. Voluntary methods are damned; compulsion extolled. The propaganda machine works ceaselessly on the accepted theory that if a thing is said often enough people will believe it.

During the past 20 years we have seen the strengthening of propaganda groups. There has been a studied policy of misrepresentation as to what a Federal health program would involve. The question of costs has been almost completely bypassed. I do not recall having seen any frank and open discussion of the degree of regimentation of patients, physicians, and institutions that would inevitably result. The compulsory program is seductively presented to the public and to Congress as one that would provide "the best modern medical care" with only slight changes in the organization of medical practice and at almost no additional cost. If the Federal officials who drafted the successive W-M-D bills were to reveal to the public and to Congress the true and inescapable characteristics of a compulsory scheme, I doubt if there would be any support for this type of legislation in Congress by organized labor or by the public at large. Only through gross misrepresentation can the scheme be sold. *And it is undeniably being sold.*

AGITATION FOR FEDERAL CASH SICKNESS BENEFITS

In 1946 the Railroad Unemployment Insurance Act was amended so that railroad employees should receive liberal cash benefits for nonoccupational sickness and accidents and for maternity. The law which went into effect on July 1, 1947, is dangerous inasmuch as it is based on the extraordinary principle that the employer is financially responsible for nonoccupational sickness benefits. The employees do not pay taxes, but receive the benefits as a form of selective private charity deceptively called "social insurance." With those benefits now in effect we may expect demands from all other groups of employees for similar charity at the expense of the employers or of the public. Nor is that all. The free sickness-insurance benefits inevitably will be followed by public medical care, financed from general or special taxes and controlled by the Federal Government.

Another law was passed in 1946 which may have seemed remote to you. It was an amendment to the Social Security Act giving unemployment compensation to maritime workers. At the same time an effort was being made to establish sickness insurance for the same group, the idea being to bring these workers into the Social Security System of the United States, and then through the ILO to agitate for cash sickness and medical-care benefits for this particular group as a prelude to similar agitation for all workers.

---

[10] Ibid., p. 209.

INTERNATIONAL LABOR ORGANIZATION INFLUENCE ON UNITED STATES

The United States, it will be recalled, became a member of the International Labor Organization in 1934, at the instance of former Labor Secretary Frances Perkins. At the same time President Roosevelt appointed a Committee on Economic Security to draft social-security legislation along the lines prescribed by the ILO for member nations. The Social Security Act of August 1935 was the first tangible evidence of our national move to the left. That act followed the Socialist line. Parenthetically, I might say that the ILO principles are now nearer to communism than to socialism. How closely our legislative proposals are hewing to the ILO philosophy is indicated in the language and definitions used. For instance, some physicians were concerned recently when Dr. Vane M. Hoge, Chief of the Division of Hospital Facilities in the Public Health Service, made the statement that the Hospital Construction Act "reflects the current concept that public health includes responsibility for the treatment and care of the individual." [11] The ILO already had proposed in 1944 that the term "health service" shall comprise "both medical and generial (i. e., public) health services." [12]

In 1927 the ILO published a volume on sickness insurance laying down the principles which we are adopting one by one in this country. In 1938 it produced the volume on administration of sickness benefits to which I have already referred. In 1944 it brought the medical principles up to date in still another volume. The provisions, language, and social philosophy of the 1944 ILO report are so like the 1943 W-M-D bill that one may surmise the same person had a hand in drafting both. Here are a few of the principles selected at random. What a familiar ring they have. Thus, the cost of the combined medical care and public health service program must "be borne collectively by all members of the community." The Communist principle of "to each according to his need, from each according to his means" is exemplified in the recommendation that each member of the community should pay into the insurance fund according to his ability and receive from the government comprehensive care of unlimited availability. The rational organization of medical-care services calls for group practice in government owned and operated or government-controlled health centers. "In Russia," so the ILO reports, "the medical-care service is based on such centers." [13] The draft schemes and plans of the ILO almost unanimously advocate and encourage some form of group practice at such government centers.

GOVERNMENT MEDICINE INCOMPATIBLE WITH PATIENT AND DOCTOR FREEDOM OF CHOICE

As to freedom of choice, the ILO states:

"The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem." [14]

Finally I would point out that the ILO admits that "the capitation-fee system suffers from the fundamental defect that doctors receive an income inversely proportionate to the amount of work involved or given." To get around that difficulty, the ILO proposes a basic salary augmented by capitation fees, or, alternatively, a full-time salary. In 1944 the ILO stated:

"A salary system is actually in force in Chile, Peru, Costa Rico, and Russia, and its introduction is proposed in the plans of the South African Medical Association, the Parliamentary Committee on Social Security and the National Health and Medical Research Council of Australia, and the Labor Party and the Socialist Medical Association of Great Britain." [15]

The Socialist program of the ILO is slowly but surely prevailing in Great Britain. The national health service is scheduled to start in England and Wales this year. Hospitals and their endowments will become the property of the state. Great Britain's 20,000 general practitioners and thousands of specialists, nurses, dentists, pharmacists, and other health personnel will be given a chance to decide whether or not they wish to become servants of the state. The medical profession has won a few weak concessions. Its original show of a united front against state control appears to have given way to a policy of appeasement. A physician no longer will have his private practice; practices will belong to the state.[16]

---

[11] Hospitals, January 1947, p. 70.

[12] Social Security: Principles, and Problems Arising Out of the War, ILO, Geneva, 1914, Report IV (1), p. 59.

[13] Ibid., p. 74.

[14] Ibid., p. 83.

[15] Ibid., pp. 89, 90.

NATIONALIZATION OF MEDICINE DEMANDED BY THE PRESIDENT

In the light of this steady progress toward state medicine in one country after another, can we afford to be complacent? We already have a national commitment to follow the Socialist, almost Communist, line of the ILO. President Truman in his state-of-the-Nation message of January 7, 1948, asked for enactment of legislation for a "national health program." [17]

Carl Malmberg, formerly a ghost writer of the Public Health Service and clerk for the Pepper Subcommittee on Wartime Health and Education, is now Administration spokesman at the Democratic National Committee. In his volume entitled "*140 Million Patients*," he made it perfectly plain that the Federal Government plan which now calls for national compulsory sickness insurance for the entire population could and probably would lead to a salaried medical service. Malmberg says: "Neither would compulsory health insurance necessarily be the final answer to our health problems. It is quite possible that the people of this country might some day decide to pay for all or most medical services out of general tax revenues, just as they pay for most educational services today. There would be many advantages in such a method. Great Britain has already taken a long step in that direction. Sweden is moving in the same direction. In the next decade several countries which now have compulsory health insurance will probably do likewise." [18]

Bureaucratic control of medicine is an ever-present threat to our freedom-loving people. Officials in the Social Security Administration have been working steadily for over a decade to gain such control. Arthur J. Altmeyer, Commissioner of Social Security; Isidore S. Falk, Director of the Bureau of Research and Statistics; and his assistant, Wilbur J. Cohen, all of whom were cited in 1947 by the Harness Subcommittee on Lobbying and Propaganda for their lobbying activities in connection with the socialization of medicine, are the outstanding Federal propagandists in the United States for the nationalization of medicine.

On December 4, 1947, Altmeyer stated to the Advisory Council of the Senate Finance Committee: "In determining how to provide adequate medical care for the people of this country it is essential that the distinction between socialized medicine and health insurance be kept in mind. *Socialized medicine implies medical services provided by physicians in the employ of the Government; health insurance implies a system whereby medical service is provided by private practitioners who are reimbursed from a special insurance fund for the services they render.*" [19]

But Altmeyer must assuredly know that when the Federal Government pays private practitioners to take over responsibility for the entire population of the United States those docors will cease to be free. They will be compelled to sign contracts with the Federal Government to become insurance practitioners and to obey the rules and regulations henceforth to be issued by bureaucrats in Washington. Despite Altmeyer's denials, doctors under health insurance would at first become virtual employees of the Government. In time they would become actual employees of the Government. For it has been freely admitted by the propagandists for "health insurance" that private practice with a fee-for-service basis of payment would be impracticable under a Government system of medicine. It has also been admitted that a capitation or salaried system would have to be adopted for administrative reasons and to keep down costs. If and when that change is made, the doctors of this country would become Government employees completely dominated by Federal officials in Washington.

This eventuality is a very real threat to doctors and patients alike. It is not remote. It is here now. The President of the United States seeks at this moment to federalize medicine. *A major political party has made national compulsory sickness insurance for everyone a political issue.* The choice between freedom and compulsion will be made in 1948 at the ballot box

---

[16] New York Herald Tribune, May 4, 1947, sec. 1, p. 22.

[17] President Harry S. Truman, State-of-the-Nation Message, January 7, 1948.

[18] Malmberg, Carl, 140 Million Patients, 1947, p. 230.

[19] Altmeyer, A. J., Statement Before the Advisory Council on Social Security—Senate Finance Committee, December 4, 1947.

Dr. SHEARON. And I might say there is voluminous literature on the subject.

Senator DONNELL. If the record does not already show that the booklet entitled "New Zealand's free medical benefits" is to be incorporated in the record, let the record now show it, and it shall be so incorporated.

(The publication referred to was inserted previously.)

Dr. SHEARON. Mortality rates have declined in all countries in considerable measure as a result of preventive health services, but sickness rates have increased greatly in countries having compulsory sickness insurance. That is very important. The duration of illness among members of German sickness funds increased from 14.1 days in 1885 to 29.3 days in 1932. And again, my reference is to Doctor Sulzbach.

9. Malingering is the universal and inescapable curse of the cash sickness benefits program of compulsory sickness and invalidity insurance. There I quote from Dr. Sulzbach: "The phenomena transcend nations and classes."

There is an enormous literature on that, and it would not be possible for us at this hearing to go into it. But it is these programs that President Truman is now recommending to Congress. So this is important material at this moment. The recommendations are made to Congress at this time to put through such programs.

10. There is great danger in developing huge Federal trust funds. Such funds would be a constant temptation, as I have before stated. There would be pressure for more and larger benefits. Governments are tempted to spend the funds for purposes other than those originally intended. In Germany the reserves "were either lent to the government or used for purposes for which the government would otherwise have had to use its own resources."

Senator DONNELL. Doctor, we will conclude at this point, and recess until tomorrow morning at ten o'clock.

(Thereupon, at 12 o'clock noon, the subcommittee adjourned until 10 a. m., Thursday, May 27, 1948.)

NATIONAL HEALTH PROGRAM

THURSDAY, MAY 27, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:29 a. m., in the committee room, Capitol Building, Senator Forrest C. Donnell, presiding.

Present: Senator Donnell (presiding).

Senator Donnell. I regret exceedingly the delay in starting the hearing this morning. It has been due to attendance in another committee hearing. Let the record show that it is 10:29 a. m.

I have for introduction into the record at this point the following: A letter from Senator Murray, addressed to myself, which states:

"I have just learned that Senator Smith will not be in attendance at the health hearings this morning. May I therefore request that you as acting chairman of the subcommittee be so kind as to have read into the record of today's hearings the attached letter which I have addressed to Senator Smith."

In compliance with the request of Senator Murray, I hereby read into the record the following letter:

United States Senate,
Committee on Labor and Public Welfare,
May 27, 1948.

Hon. H. Alexander Smith,
United States Senate, Washington 25, D. C.

Dear Senator Smith: I regret the fact that hearings have been scheduled for the same hours this week on the Taft-Hartley Act, the extremely critical steel shortage, and the two health bills before this subcommittee. Since I am a member of all three committees and since the subject matter before each is of great importance, my decision as to which of the three to attend must be governed by the value of the testimony being presented at each.

On that basis I cannot but conclude that my time would be much better spent at the hearing now being conducted by the Small Business Committee on the current steel shortage and will not be able to personally attend the health hearings before their probable adjournment.

I respectfully request therefore that you instruct the clerk of the committee to insert in the record of these hearings the following items and at the designated places:

1. An analysis prepared by Senator Pepper's staff and my own, of the committee print in which the introduction and conclusions of the Brookings report were made available to us and to others.

(To be inserted on the record following that committee print.)

2. An analysis of the Brookings Report which, at my request, is being made by the Committee on Research in Medical Economics and the Public Affairs Institute. (To be inserted after item 1.)

3. A series of statements bearing on the validity of the testimony presented by Dr. Majorie Shearon and on her reliability as a witness, which statements represent materials I had hoped to bring out in cross-examination and which will, I

am sure, prove of considerable value not only to my colleagues on this committee but to those other members of the Congress whom she has influenced and to the medical profession as well.

4. Such rejoinders as Dr. Shearon may care to make to the statements referred to above.

5. Other materials casting light on matters now in the record.

These items will be sent Mr. Rodgers before June 5th.

I also respectfully request that the analysis referred to in Item Two above be printed separately as a Committee Print so that its contents will be available to us in as readable and accessible a form as was the Brookings Report. I ask too, that it be printed in as many copies and for the same distribution as was the print of the Brookings Report.

And, finally, I ask that this letter be set forth in the record of today's hearings.

In conclusion, I wish to again express my regret at my inability to attend and to publicly express my appreciation for the many courtesies which you, as chairman of this subcommittee, have extended during these long-drawn-out hearings on S. 545 and on S. 1320 and for the fairness and rigid impartiality with which you have conducted them.

Sincerely yours,

[s] JAMES E. MURRAY.

Senator DONNELL. The request of Senator Murray having been complied with, Doctor Shearon will kindly proceed.

STATEMENT OF MARJORIE SHEARON, PH. D.—Resumed

Dr. SHEARON. Senator, yesterday you asked me to insert into the record the clipping in regard to deficit financing, and I offer that now.

Senator DONNELL. That is the statement by Secretary Snyder?

Dr. SHEARON. By Secretary Snyder; yes.

Senator DONNELL. This is a clipping from the Washington Post of Tuesday, May 25, 1948, which I request the reporter to copy at this point in full in the record of this proceeding, and to cause the clipping to be returned to Dr. Shearon after such copy shall have been made. Go right ahead, Doctor.

(The clipping referred to is as follows:)

[The Washington Post, May 25, 1948]

NATIONAL DEBT OF 252 BILLIONS MAY BE BOOSTED, SNYDER SAYS

ATLANTIC CITY, N. J., May 24 (AP). The national debt of 252 billion dollars may be increased during the fiscal year starting July 1, Secretary of the Treasury Snyder said today.

Snyder said that not only will debt reduction "probably" come to an end but that a return to deficit financing by the Government is a "definite possibility."

The Secretary expressed his views at a news conference and in an address to the twenty-eighth annual conference of the National Association of Mutual Savings Banks.

The recent reduction in personal income taxes, plus the demands of the European recovery and domestic rearmament program, are the main factors which could force the Government to operate in the red once again, Snyder said.

He indicated that at the moment inflationary forces seemed to be fairly well under control, but added:

"The cumulative effect—if any—of the cut in income taxes, ERP, and domestic rearmament will not be apparent until late fall."

The Secretary held out the hope that even if debt reduction comes to a halt in the year ahead, the Government may still be able to reduce further the volume of marketable debt.

"Only a portion of the 252 billion dollars of Government indebtedness is in the form of marketable obligations," he told some of 600 savings bankers. "The remainder is in the form of savings bonds, savings notes, special issues to Government trust funds, and other nonmarketable obligations.

"This nonmarketable part of the debt may go up by something like three billion dollars during the year ahead, thus permitting a reduction in the total of the marketable debt.

"This is due primarily to the intensity with which we are pressing—and will continue to press—our savings bond campaign."

DAY-TO-DAY WATCH

The Treasury, Snyder continued, is watching the money market on a day-to-day basis.

We will consider raising the rate on United States certificates of indebtedness "when and if the time comes," he added.

An increase in the certificate rate—the price the Government pays for borrowing money for 1 year—has been widely anticipated in banking quarters.

A few days ago, however, the Treasury announced that certificates would continue to be sold, at least up until September, at a rate of 1⅛ percent instead of an expected 1¼ percent.

Earl B. Schwulst, president of the association and executive vice president of the Bowery Savings Bank, reported that mutual savings banks hold deposits of more than 18 billion dollars, a new record. Increases in the first quarter this year, he said, amounted to about 248 million dollars.

Schwulst noted, though, that the rate of growth of savings has declined from a year ago.

Dr. SHEARON. I think you might also like this additional clipping about Miss Frieda B. Hennock, from the New York Times, which is a more full account than the one we had yesterday.

Senator DONNELL. The clipping from the New York Times of May 25, 1948, with respect to Miss Frieda B. Hennock, will be included and the contents of it copied into the record. Will you proceed, please, Doctor?

(The clipping referred to follows:)

WOMAN NOMINATED AS MEMBER OF FCC—TRUMAN PICKS MISS HENNOCK, LAWYER IN NEW YORK FIRM, AS SUCCESSOR TO DURR—FIRST OF SEX TO BE NAMED—APPOINTEE, A LIBERAL DEMOCRAT, DUE FOR 7-YEAR TENURE—AIDED O'DWYER'S ELECTION

Washington, May 24—President Truman sent to the Senate today the appointment of Miss Frieda B. Hennock of New York as a member of the Federal Communications Commission.

If confirmed, Miss Hennock will serve a term of 7 years, beginning July 1. She would succeed Clifford J. Durr, whose term expires June 30.

Miss Hennock received strong support for the appointment from Paul Fitzpatrick, New York State Democratic Chairman; Edward J. Flynn, Bronx Democratic leader, and Mrs. India Edwards, director of the women's division of the Democratic National Committee.

She is regarded here as a leader in the liberal wing of the Democratic Party. It was said that the support she received from the New York Democratic leaders was in part a reward for her intensive work for the election of Mayor William O'Dwyer.

JOINED BAR AS YOUNGEST WOMAN

Frieda B. Hennock is a member of Choate, Mitchell & Ely, corporation lawyers, at 41 Broad Street. She joined the law firm, established 140 years ago and one of the oldest in the country, in 1941. Previously she had practiced independently in both criminal and civil law. She became the youngest woman lawyer in New York at the time of her admission to the bar in 1926.

Miss Henneck served as assistant counsel to the Mortgage Commission of the State of New York from 1935 to 1939 and also taught in 1937 at the Brooklyn Law School, from which she received her own degree. She is a member of the executive committee of the National Health Assembly.

Politically Miss Hennock has been active in both the New York State and national campaigns of the Democratic Party. She is not affiliated with Tammany or any other local political organization.

WOULD QUIT PRESENT POST

President Truman's selection for the Federal Communications Commission acknowledged that she had Democratic backing for a place in the regulatory body, where, granted that the Senate approves her appointment, she will be the first woman to be seated. She said that she has never held any other public office.

Miss Hennock said that she would resign from the firm with which she is now associated to join the FCC. She also said that she was keenly interested in assuming the Federal post, which carries a salary of $10,000 annually. It was indicated that her present income is substantially greater than that stipend.

Born in Kobel, Poland, about 43 years ago, Miss Hennock came to this country 6 years later with her parents, Sarah and Boris Hennock, both now dead. She has been a resident of this city since, her present address being 77 Park Avenue. She has five sisters and two brothers.

Dr. SHEARON. We stopped yesterday at paragraph 10, on page 31. I will resume where we were interrupted.

In Germany the reserves "were either lent to the Government or used for purposes for which the Government would otherwise have had to use its own resources." That is also a citation from Dr. Sulzbach.

11. Patients and practitioners alike have been deprived of freedom of choice when compulsory insurance has been made universal. Ultimately no one can remain out of the system when the entire population is taxed to support the system and everyone is promised free benefits.

I might say there that at the time Senator Wagner introduced S. 1606 on November 19, 1945, Senator Lister Hill asked him what the coverage would be, and he said it would be total for the entire population.

I am quoting here:

> It is not compulsory health insurance as such that affects the medical profession in the first place, but the percentage of the population which it covers. * * * In Germany, the doctors kept a substantial independence since they earned a generous 40 percent of their incomes through private practice.

That is a quotation from Dr. Sulzbach.

In New Zealand a modicum of freedom was retained by physicians and patients after the original Social Security Act was amended for that purpose. But there is the constant threat that the New Zealand Government will outlaw the private practice of medicine. As a matter of fact, such a bill has been drafted, but has not been introduced, in New Zealand, to outlaw the private practice of medicine, and to insist that all doctors come in under the Government scheme, and that all persons shall accept Government medicine.

The ILO admits that private practice will disappear under a universal system of sickness insurance for the entire population. This has been quoted before, but I think it would be advisable to quote it again. It is a brief statement by the International Labor Organization in their report entitled: "Approaches to Social Security—An International Survey". This is "Studies and Reports, Series M Social Insurance No. 18," published in Montreal in 1942. This is an admirable document. It summarizes the history of social insurance and of social-systems throughout the world. It specifies what is likely to happen with different systems, what has already happened, and, with respect to insurance schemes covering the entire population, the type of insurance that is contemplated in S. 1320, I quote from the ILO, which says, on page 50——

Senator DONNELL. Now, Doctor, is this a report by the ILO, or is it some committee?

Dr. **Shearon.** No, it is a report by the ILO, by their paid staff, summarizing all their knowledge up to that time, in 1942, giving it in very concise form. It is an excellent book, and is a staff report for the general information of the public. I am quoting:

> The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. The next step to a single national medical service is a short one, and a bill to create such a service is now under consideration in Chile.

12. "Social Insurance has the tendency to expand beyond the scope originally envisaged. Driving forces behind its expansion are the vested interests of the bureaucracy and the general lack of comprehension of the consequences involved."

That is a very important quotation from Dr. Sulzbach, that when you adopt a social security program, the legislators who do it do not understand the consequences that are involved, and the groups that ask for such expansion also do not understand. I should like to insert in the record at this point a statement from the Washington Post of May 27.

Senator **Donnell.** May 27, 1948, this year?

Dr. **Shearon.** Yes, this year, in connection with the cuts in the Social Security fund. This is directly applicable to what I have just said.

Senator **Donnell.** That is today?

Dr. **Shearon.** That is right, today. It is hard to keep track of the days: It is from The Washington Post this morning. I might say the reason I suggest that this be inserted is that at 2 o'clock this afternoon the Senate Appropriations Committee will begin marking up the Federal Security bill, putting in the sums that are to be approved by the Senate. Of course, the great question is whether or not those House cuts will be retained. It is, therefore, a very important time. Now we have this editorial in the Post this morning.

I might say the Washington Post, insofar as editorial and policy statements are concerned, is something of the right arm of the Federal Security Agency. On the Post is John J. Corson, who was formerly with Mr. Altmeyer. I recall, for instance, when I consulted a member of the Social Security Board some years ago in regard to a statement that had been circulated, he said "Oh, that is all right. I will get that fixed up. I will have an article put in the Post." In other words, it is very easy for them to get an article in the Washington Post. And, if you have followed the editorials that have appeared with relation to social legislation, particularly in the social security field, you will have noticed that those editorials go along with the requests and the demands of the officials in the Federal Security Agency and the Social Security Administration.

Senator **Donnell.** This article appearing in today's issue of the Washington Post will be incorporated in full at this point in the record, and the clipping after being copied into the record will be returned by the reporter to Dr. Shearon.

(The editorial referred to is as follows:)

[Washington Post, May 27, 1948]

SOCIAL SECURITY FUNDS

Senator Knowland's Appropriation Subcommittee holds the fate of the social security program in its hand. It is now studying the wreckage left by the House when that body followed Representative Keefe's lead a fortnight ago and cut the budget request for the office of the Social Security Administrator by no less than 93 percent. The effect, if the Senate should acquiesce in it, would be to make effective administration of the Social Security system impossible. There would be no adequate funds for research, for information or for planning. Economy was, as usual, the pretext for this reckless pruning. But the real motive appears to be a desire of the Republican leadership to narrow the coverage of the unemployment and old-age insurance systems, despite its 1944 platform pledge to extend these to all employees not already covered.

A look at the Social Security appropriation, as approved by the House, in relation to that of another comparable agency, should make this fact quite plain. The House awarded $1,500,000 to the Public Health Service for administrative management; in view of this agency's 16,500 employees and tremendous responsibilities, this is by no means excessive. But the Social Security Administration, operating in an area equally important and with some 13,000 employees, was given only $191,000 for administrative purposes. We hope the Senate will restore the funds requisite to a successful program.

Dr. SHEARON. Now, coming to my recommendations: I shall make two sets of recommendations, one professional, the other professional-political, admitting that they mix but poorly.

Recommendation 1.—A. In the light of the volume of conflicting testimony which has been offered, and of the well-substantiated attacks by competent authorities on the credibility of some Government witnesses and reports, I think this subcommittee would be acting in the best interests of the public if it withdrew health legislation of the type embodied in S. 545 and S. 1320 entirely from the political arena pending further investigation of certain officials in the Federal Security Agency.

Senator DONNELL. What do you mean by that expression, Doctor?

Dr. SHEARON. Well, at the present time we have a legislative program set forth by the President of the United States. It was originally set forth on November 19, 1945. It has been repeated since then in a number of special messages, this one of May 24 being the most recent one, in which the health program of the country has been made a political issue, backed by a political party and the officers in the Federal agencies have been asked to go along with the President in support of that program.

That is the first time in the history of the United States that a President has asked that medical care and related services be made a political issue, and that is what is shaping up at the present time through the National Health Assembly, the well-timed report Mr. Ewing will give to the President early in June, just before the two political conventions, and the question as to whether or not political parties shall include in their platforms a plank for compulsory health insurance.

That is what is meant, by me, by "the political arena."

Now, Senator Murray has stated that he has no desire to alienate the physicians of the country, that he had not supposed his bill would have that effect, and that, assuming that Senator Taft and the other persons who introduced S. 545 were willing to withdraw it from the political picture and to say that the health of the country should not be made a political football, he would go along on that same recommendation. And he asked my advice about a number of different ways in which this might be done, and he suggested that I might help him in drafting, perhaps, an alternative bill.

I myself think that the health of the country is not going to be improved particularly by any medical bill. That is not the way for the people to get health, and you cannot pass a law in Washington and then say the people of the United States will have health.

Since I originally worked on S. 545, I have come to have a great many doubts, more doubts than I had in the beginning, as to the advisability of such a bill. You have had some doubts, I know, all along. And now I think it is significant that Senator Murray is having considerable doubts about his own bill, and that he himself would be willing to go along, say, on some nonpartisan basis in drafting legislation, if it is decided that any legislation is needed. And I think that is a great question that has to be answered by this subcommittee. Have I made that clear?

Senator DONNELL. Well, generally speaking, I get your point, Doctor. That is all right. Go right ahead.

Dr. SHEARON. Much of the thinking of the Congress and of the public regarding so-called unmet health needs and the urgent necessity for Federal intervention with respect to the distribution of medical care and related services has been shaped by reports which have been put out by the Social Security Board—now Administration.

Senator DONNELL. In the statement you made a few minutes ago you spoke about further investigation of certain officials in the Federal Security Agency. Do you care to elaborate on what officials they are, and what should be the scope of that investigation?

Dr. SHEARON. I cannot recall whether anything has been put into the record since last summer regarding the investigations by the Harness subcommittee. We had some information put in. There was a House report that was put out on July 2, 1947, and I am sure that has been inserted in toto in the record.

Last summer, at the time of that mission to Japan, Congressman Harness wrote a letter on September 9, 1947, to the Honorable John Taber, chairman of the Committee on Appropriations in the House of Representatives. If that letter has not been introduced, I think it should be, because it refers to the activities of these particular Federal officials who have been so active in writing the legislation and in preparing the reports sponsoring it.

Senator DONNELL. The order will be that at this point the reporter will kindly provide that if it develops this letter dated September 9, 1947, from Mr. Harness to Mr. Taber, has not hitherto been introduced in the record, that it is hereby admitted and will be placed in the record following the conclusion of the testimony and previous exhibits already authorized to be placed in the record following said conclusion.

(The letter referred to is as follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLICITY AND PROPAGANDA,
OF THE COMMITTEE ON EXPENDITURES IN THE EXECUTIVE DEPARTMENTS,
Washington, D. C., September 9, 1947.

Honorable JOHN TABER,
Chairman, Committee on Appropriations,
House of Representatives, Washington, D. C.

DEAR CONGRESSMAN TABER: The subcommittee investigating publicity and propaganda in the executive agencies, of which I am chairman, learned recently that the Social Security Administration, the United States Public Health Service, and the Public Housing Authority have sent a special health mission to Tokyo with a view to assisting in the formulation of a new national health program for Japan. This mission is operating on a temporary basis as a function of the War Department.

In a letter addressed to Mr. Watson B. Miller, Administrator of the Federal Security Agency, under date of August 6, 1947, the Secretary of War stated the objectives of the mission were "to consult with the public health and welfare and with the Japanese Committee on Social Insurance and Japanese Council on Medical Care for the purpose of drafting a national health bill which will incorporate a unified national health program with a national medical care program. This bill must be available to present to the Diet not later than October 1, 1947."

I deem it proper to bring this matter to your attention because it appears to me to involve a question of legislative policy for the consideration of the Appropriations Committee. All members of this mission are permanent, full-time employees of the Federal Government and are well known in the United States for their persistent agitation for a national system of socialized medicine to be achieved through a program of compulsory health insurance. The members of the mission are Joseph W. Mountin, Associate Chief, Bureau of State Services, United States Public Health Service; Burnet M. Davis, surgeon, United States Public Health Service; Barkev S. Sanders, Chief, Health Studies Division, Bureau of Research and Statistics, Social Security Administration, and Frances A. Staten, Assistant Regional Director for Management, Federal Public Housing Authority.

This mission departed for Tokyo on August 28, 1947. We are informed that at a later date the mission will be expanded to include Mr. Arthur J. Altmeyer, Commissioner of the Social Security Administration; Mr. Wilbur Cohen, Assistant Director of the Bureau of Research and Statistics, and possibly Mr. I. S. Falk, Director of the Bureau of Research and Statistics.

In reply to allegations by the War Department that protests against this mission have been based on lack of information, please be advised that my statements are founded upon what purports to be the complete file of the War Department in this matter. These files indicate definitely that the plans for the mission were originated by key agitators for socialized medicine on the Federal pay roll in Washington and their collaborators on the Federal pay roll in Tokyo; that very close liaison was maintained among the two groups, and that the basic purpose of the mission is the establishment of socialized medicine in Japan.

In preparation for the mission, a civilian employee, Mr. Stanchfield, was sent to Tokyo to make a preliminary survey of social security and health needs. Thereafter Mr. Stanchfield proposed the mission to Arthur J. Altmeyer, Commissioner of the Social Security Administration, and on March 5, 1947, Mr. Altmeyer in a letter to the War Department designated the personnel to be included in the mission, and suggested Mr. William H. Wandel, Chief of the Program Division, Bureau of Unemployment Security, as a member, and suggested that Mr. Wandel precede the mission to Japan by about 3 months and that he should remain 3 months after the mission had completed its visit to Japan to finish up any necessary details, and he further suggested that while in Japan on the mission, Mr. Wandel serve as Chief, Social Insurance Division, Public Health and Welfare Section of the Supreme Command for the Allied Powers (SCAP).

It is apparent from the letter herein referred to from Mr. Altmeyer to the War Department that the personnel of the mission and the planning of its program was dictated and originated in and from the Social Security Administration in Washington. There is nothing in the entire record before us to indicate or suggest that the need for the mission was suggested originally either by General MacArthur or any responsible Japanese source. To the contrary, our records contain a letter under date of June 14, 1947, from William H. Wandel, Chief of the Social Security Division, Public Health and Welfare Section of SCAP, to I. S. Falk in Washington, outlining the real purposes of the proposed mission. In this letter Mr. Wandel said in part:

"We now think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan. * * * Permanent revision requires amalgamating national health insurance with health insurance on a compulsory basis."

In a letter from William H. Wandel from Tokyo to I. S. Falk, of the Federal Security Agency, Mr. Wandel exposed the fact that there were conflicts of interests as to the purposes to be accomplished when he stated: "I find the work here very interesting and engrossing. One is reminded forcibly of the apparently universal character of the conflict of established interests, but nevertheless there are real possibilities for accomplishment. I am glad I came out."

It has also come to the attention of our committee that Dr. B. M. Davis, one of the members of the Tokyo mission returned only recently from London, where he was attached to the British Ministry of Health, to assist in the national program for socialized medicine in England. He is the son of Mr. Michael M. Davis, chairman of the Executive Committee of the Committee for the Nation's Health, the foremost lay organization agitating for socialized medicine in the United States, as embodied in the Wagner-Murray-Dingell bill. The Committee for the Nation's Health, as our previous reports have delineated, is the principal national organization in the United States engaged in distributing the propaganda of the Social Security Board supporting socialized medicine.

I feel strongly that the question fairly arises as to when these gentlemen work for the people of the United States who pay them? Our committee has already traced out their operations in New Zealand, in England, in Latin America, and finally in Japan. Personally I feel that if the American taxpayers are supporting a world-wide movement for socialied medicine, then the people are entitled to know it and to know how much such international activities are costing them.

We have been investigating this situation for 6 weeks. Our conclusions to date are as follows:

1. That the health mission to Japan is composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.
2. That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.
3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.
4. That the nominal request for the mission was engineered through the general headquarters of the Supreme Commander in Tokyo by Federal employees sent from Washington for that particular purpose.
5. That Gen. Douglas MacArthur does not favor, and does not approve, any plan to establish compulsory socialized medicine in Japan.
6. That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk under date of June 14, 1947, is a gross misuse of public funds.
7. That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.
8. That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved.

I deem it inappropriate for Federal employees, at the expense of the American taxpayer, to travel throughout the world preparing or assisting in the preparation of legislation to be adopted by foreign countries when similar legislation, long pending, has not been approved by the Congress of the United States.

We are continuing our investigation of the origins and real purposes of the Tokyo health mission. Meanwhile we believe that your committee would want to have these facts before it when the next appropriation bill comes up for the Public Health Service and the Social Security Board.

I am most anxious to cooperate with your committee, and will be happy at any time to make available to you or your staff the documents assembled by the staff of my committee in regard to this matter.

Sincerely yours,

FOREST A. HARNESS.

Dr. SHEARON. As a matter of fact, I would not like at this time to interrupt the train of my thought here in answering some of the statements that were made; for instance, in regard to the mission in Japan, a little more should be said about that.

Senator DONNELL. Well, I thought you might be able to tell us just what particular officials they are, and what should be the scope of the investigation. I do not think it need be gone into extensively, such as giving us all of the names.

Dr. SHEARON. There were some twenty-odd officials in the Federal Security Agency who had been connected with sponsoring health workshops, and then after that, some were active in connection with the mission to Japan. The persons mentioned were Mr. I. S. Falk, Wilbur J. Cohen, Barkev S. Sanders, Joseph W. Mountin, Burnet M. Davis, M. D., and Francis A. Staten.

That was in connection with the mission to Japan. And following the investigation by the Harness Subcommittee on Lobbying and Propaganda, last summer Tom Clark of the Department of Justice was asked to investigate these officials. He made a cursory examination of the testimony that had been already gathered in the House, and sent a statement to the Federal Bureau of Investigation, asking that an investigation be made of these officials in connection with their activities in running health workshops, with a view to promoting the enactment of the Wagner-Murray-Dingell bill. That investigation was made by the FBI. They worked on it for several months. The report is now, as I understand, locked up in the Department of Justice, and cannot be pried loose.

And I would say in connection with that investigation, that any study of these health workshops is merely playing around with the rather small and unimportant officials, for the most part, who have not been doing the major thinking, planning, and writing in connection with this whole movement. So that when the Harness subcommittee in its first investigation limited itself to the health workshops, and limited the request to the Department of Justice, it decidedly limited the investigation, and it may not be anywhere near so productive of results as if they had gone into this whole problem of the movement for the nationalization of medicine.

It was the original intent of the Harness subcommittee to go into the whole movement, but they had become so much involved in other investigations that I do not know if they will have time to come back to it. They intended to do so in January, but have not done so.

Anyway, there has been an investigation, and I might say there have been other investigations in the past, the reports of which have not been published. It has been the general consensus of opinion that nothing could be done in regard to these Federal officials.

Turning now to the research material published by these officials, we note that certain of these reports have been purposely biased and intentionally misleading. I am referring to reports put out by the Social

Security Board—now Administration. Although the FSA has access to health and medical reports from all parts of the world, and although its top officials at the bureau level are fully cognizant of the importance of honest interpretations of factual material, the Congress for nearly a decade has been misled by those officials deliberately for selfish purposes not in the public interest. The officials in question cannot plead ignorance of the significance of their actions. Being highly trained, they know what they are doing. But because of their high training they are doubly responsible to the Congress and to the public. Noblesse oblige! Some of those officials have failed to regard a public office as a public trust. They have issued, or connived at the issuance of, inaccurate reports published at public expense, and mailed in large quantities under the Government frank. The reports have been initiated by these officials for the purpose of influencing the Congress and of creating a climate of opinion favorable to the type of legislation which they themselves have written. Were the legislation enacted, the officials in question would be likely to profit greatly in increased salaries, power, and prestige.

I have two exhibits—and, oh, yes, "Federal Propaganda for the Welfare State," which I should like to have inserted.

Senator **Donnell**. It will be so inserted.

(The publication referred to is as follows:)

Socialized Medicine

Enchainment of physicians and patients by regulative interference

[Vol. I. No. I]

FEDERAL PROPAGANDA FOR THE WELFARE STATE

(By Marjorie Shearon, The Shearon Medical Legislative Service, Washington, D. C.)

The Author

Marjorie Shearon, Ph. D., scientist, lecturer, and legislative consultant, was formerly research analyst to the Senate minority conference (1945–46) and health consultant to the Senate Committee on Labor and Public Welfare (1947). Prior to that she spent nearly a decade in the executive branch of the Federal Government, 5 years with the Social Security Administration and 4½ years with the United States Public Health Service.

Prior to her 15 years of public service—Federal, State, and local—she was engaged in scientific research in the biological sciences, her original contributions to science being in the field of evolution. A fellow of the American Association of University Women, past fellow of several national scientific societies, she is a member of Phi Beta Kappa and Sigma Xi.

She is the author of numerous scientific articles and of: Economic Status of the Aged; Health and Disability Legislation in the States—1939; Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interference; Federal Propaganda for the Welfare State; and Paradise Unlimited—the Menace of the Police State. She is author of American Medicine and the Political Scene, a weekly analytical news release which she publishes as director of the Shearon Medical Legislative Service.

(Copyright by the Shearon Medical Legislative Service, second printing, January 1948.)

ALLEGED JUSTIFICATION FOR THE WELFARE STATE

One of the basic issues in the 1948 Presidential campaign will be whether or not a welfare state is to be established in this country. By a welfare state I mean a form of central government which would provide a wide range of cash, service, and other benefits to the entire population at public expense and which would control the people by "regulative interference." Justification for establishment of a welfare state is based on the alleged need of the people for greater economic security, better nutrition, and sounder health than can be provided by the majority of the population through their own efforts. The more abundant life, it is claimed, can be obtained only through Federal intervention and the development of a national welfare program to protect the entire population from life's major hazards.

President Truman in announcing his legislative program on November 19, 1945, called upon Congress to enact a series of health and welfare laws. The legislation which has thus far been introduced into Congress to implement the Truman program would gradually transform our system of government into a welfare state which, for centralization of power and of public revenues, would surpass the Communist state in Russia and the Socialist state in Great Britain.

The first step in creating such a planned or compulsory economy would be enactment of a Federal law for national social insurance either through piecemeal legislation or through a series of bills purportedly for the general welfare. The blueprint for such legislation has already been presented to Congress in the comprehensive Wagner-Murray-Dingell bill of 1943 (S. 1611 of the 78th Cong.); in a similar, more grandiose omnibus bill in 1945 (S. 1050 of the 79th Cong.), and in five bills in 1947 (S. 712, S. 1320, S. 1679, S. 1714, and S. 1734 of the 80th Cong.). This over-all blueprint for comprehensive compulsory national social insurance should be kept in mind because it is the *sine qua non* of a welfare state. The law *must* be comprehensive, it *must* be compulsory, and it *must* be national if the planned welfare state is to be set up.

National social insurance, it should be remembered, is designed to do three things: raise revenues, control people, and redistribute wealth and income. Universal "health insurance," or more properly speaking, sickness insurance, is on of the control measures contemplated. The full extent of the plans for governmental regulative interference cannot be appreciated by studying piecemeal legislation such as the bills for medical care insurance, or maternal and child health, or cash sickness benefits. These isolated bills cannot be divorced from their context of omnibus compulsion. One must not lose sight of the long-time objectives while quarrelling over the detailed provisions of separate bills.

The idea of social insurance is new in this country where, until the passage of the Social Security Act in 1935, our experience with compulsory insurance had been limited to State workmen's compensation laws. The Social Security Act, outgrowth of the depression, was hailed as a great humanitarian measure and was passed with the overwhelming approval of all political parties. Major emphasis was placed on old-age insurance because of its great popular appeal and seeming social justification. Unemployment insurance was almost equally popular as the country emerged from the long siege of unemployment in the early thirties. The act likewise provided modest grants-in-aid for expanded public-health services and for assistance to dependent children, the aged, and the blind. Few saw reason to fear or to distrust a law providing Federal aid and even compulsion for social objectives seemingly so desirable.

Had we then seen the total scheme in the minds of the planners who pushed the Social Security Act through Congress and who a little earlier maneuvered us into the Socialist-dominated International Labor Organization, we might have paused before embarking on a program and accepting a set of principles so alien to our way of living and thinking. At that time we unwittingly accepted the basic tenets of collectivism as opposed to those of individualism.

REGULATIVE INTERFERENCE

The Social Security Act bears the label "made in Germany." Historically it goes back to Bismarck's legislative program for state socialism and to the principles of social legislation later laid down by the International Labor Organization. To understand the *real*, rather than the *avowed*, purposes of the Social Security Act, one must turn to the objectives set forth by Bismarck and his economic adviser. According to Bismarck's plan announced in the 1880's, the state was gradually to assume ownership of banking, insurance, and communications and was to set up a system of state "insurance against sickness, incapacity, and old ag." The hard-pressed German Chancellor proposed a new type of tax, a payroll tax, which, it was asserted, would serve the dual role of raising revenues and of bringing about the desired "regulative interference" with the lives of the people.

The "interference" was designed to bring under federal regulation the distribution of income and wealth as well as the purchasing power and living habits of the "lower classes." The latter form of "interference" was to be accomplished by administrative rules and regulations and by compulsion. Bismarck's economic adviser stated, "This two-sided policy of taxation I call social. The second side here advanced * * * is based, as concerns the mass of the population, the lower laboring classes, on the assumption that in the truest interests of the nation a guardianship may and must be exercised over the national consumption or even the application of income to personal purposes."

Bismarck's so-called "social" insurance laws were acclaimed as the "high-water mark of German state socialism" 60 years ago. We should note well and never forget that they were congeries of laws embracing political and economic devices rather than genuine social measure. The point has been well made that social insurance is neither social nor insurance. As a matter of fact, it merely provides an ingenious taxing system and a clever device for "regulative interference" by an all-powerful central government.

The first national compulsory sickness insurance law was enacted in Germany in 1883. It not only became the model for similar laws in over 30 other countries but it also established the techniques of intrigue, misrepresentation, and dishonest propaganda which have marked the stormy path of compulsory legislation for over 60 years. The legislative pattern which has gradually been developed is as follows: Bills are drafted by nonmedical, government experts in the executive departments which are seeking increased power. Bureaucratic economists and social planners do the drafting sometimes without legal advice. The medical profession is either bypassed entirely or consulted perfunctorily. Tax rates are decided upon and are as large as the traffic will bear. Authority is given to government officials to draft rules and regulations for administering the program. The legislation is sold to the public, to the legislative body, and to labor by misrepresenting the objectives, the contemplated methods of administration, and the end results. Freedom of choice is promised to physicians and patients alike; benefits are glowingly described; costs are scarcely mentioned. The scheme is publicized as an *insurance law* under which beneficiaries are entitled to complete medical care as a right by virtue of a token payment in the form of pay-roll taxes.

SOCIAL INSURANCE AS A "RIGHT"

It was Bismarck's idea that the so-called lower classes could be sold on the principle of "compulsion" and would submit to control by a powerful bureaucracy if they were promised certain benefits, including government-controlled medical care, as a "right." The bitter pill of compulsion was to be sugar-coated with the false claim that workers would henceforth be insured by the state and would thus avoid the stigma of public charity.

The same sales talk is being used today in this country in selling the Wagner-Murray-Dingell bills to Congress, to organized labor, to welfare groups, and to the public at large. Benefits are maximized, costs minimized. False promises are made by the bureaucrats who draft the legislation and by the lobbyists, inside and outside the Government, who are working to push the bills through Congress. Although our national income is nearing the annual rate of $200,000,000,000, arguments based on national needs when our income was one-fifth that amount are still being solemnly presented to Congress to justify Federal intervention in our daily lives. Senators, obviously misinformed about the legislation, are duped into lending their names and prestige in support of measures they would probably not support if they understood them. I do not doubt that President Truman himself has been sold a bill of goods without having any real appreciation of the long-range implications of parts of his legislative program.

Let me illustrate by giving a few examples of glaring misrepresentation in the publicity being disseminated by Federal officials and certain Members of Congress who take their cue from those officials. Physicians are told that they will have a voice in deciding whether payment is to be made on the basis of capitation, fee-for-service, or salary. This myth was exploded when, under the penetrating cross-examination of Senator Donnell of Missouri at the health hearings this year, Michael M. Davis, one of the prime movers for the nationalization of medicine and chairman of the executive committee of the lobbying group, the Committee for the Nation's Health admitted that we would probably come to a capitation system if the Wagner-Murray-Dingell bill were enacted. Dr. Ernst P. Boas, chairman of the lobbying group known as the Physicians Forum, has likewise stated that: "Insurance guaranteeing complete medical coverage cannot be set up, except at prohibitive cost, if the fee-for-service principle is retained."

It is thus perfectly clear that if the Wagner-Murray-Dingell bill were enacted into law our entire population of 143,000,000 persons would ultimately be herded into a panel system like that which obtained for 35 years in Great Britain and which served as a precursor to the current plans for a salaried service. Patients would become Federal pawns, worth so much per head per year to the physicians on whose lists they appeared.

But this is by no means all that would happen if we had a system of sickness insurance in a welfare state. We are told by the Federal Security Administration that patients would be free to accept or reject the benefits of national social insurance and that physicians would be free to enter the system or to remain outside as they saw fit. The Federal officials who initiate such statements for the purpose of allaying fears of regimentation, *know* they are not speaking the truth. They *know* that a very considerable portion of the population would not be able to afford to pay the increased social-security taxes of 6 percent on pay rolls together with the increased income taxes that would be required to finance the social-insurance deficit and at the same time to pay for the private purchase of medical care. These same Federal officials *know* that members of the medical profession would ultimately be forced to sign contracts as federally controlled insurance doctors unless they adopted a national policy of noncompliance as was done in Australia, is contemplated in Great Britain, and has been proposed in this country. If part of the profession were to sign up—and the debacle would start with the least capable physicians and with Communist sympathizers—there would be increasing difficulty for the remaining members of the profession to retain their freedom. The area of private practice would dwindle through a slow process of erosion. General practitioners would be squeezed out of private practice as competition for insurance practitioners increased. Specialists would find it impossible to reach a sufficiently large population from which to develop an adequate practice.

A SINGLE NATIONAL MEDICAL SERVICE

The International Labor Organization, which 20 years ago revised Bismarck's blueprint for socialized medicine and proposed the principles now being followed in this country by the authors of the Wagner-Murray-Dingell bill, stated in 1942 that:

"* * * once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. *The next step to a single national medical service is a short one.* * * *" [Emphasis mine.]

I will not here go into the question of deterioration of medical practice under compulsory insurance. The subject has been discussed many times. But I will say that if the Wagner-Murray-Dingell bill is enacted into law in the near future and the Federal officials who drafted the health and medical provisions retain their present positions, you may rest assured there will be little or no consultation with medical groups in the writing of the all-important rules and regulations which would control not only all the health professions (physicians, dentists, nurses, technicians, etc.), but also hospitals, health centers, medical schools, and research centers.

The officials who wrote the Wagner-Murray-Dingell bill without consulting the professions which are concerned have designs of far broader scope than most persons realize. Federal sickness insurance alone would give them access to anywhere from *6 to 10 billion dollars a year* of tax funds. The total social security program when fully mature would take at least 20 percent of the national income. If the Federal planners should succeed in their schemes they would induce Congress to transfer the tax-collecting power from the Bureau of Internal Revenue to the Federal Security Agency. They would control the national social-insurance trust fund, even as Hitler controlled the German social-insurance funds. To entrust such vast sums to a few Federal officials who are not elected representatives of the people and who, in the future as in the past, might act as though they were laws unto themselves, is sheer folly. No bureaucrat and no political party should be able to control such funds and such power. These same officials would recommend to Congress ways in which the trust funds should be spent. They would determine capitation rates, hospital rates, and other scales of payment for services. While in advance it might be made to appear that the professions would be consulted about these matters, in reality, after the basic compulsory law was on the Federal statute books, pay scales would be determined by the amount in the health insurance fund and by the whims of Federal officials who were drafting the provisions for regulative interference.

POLITICAL PROMISES

The full intent of these plans has not been revealed by the nationalization propagandists. The public has been led to believe that there would be no change in the present form of medical practice except that there would be no payment for services at the time of their receipt. The sales talk runs something like this: We in America are insurance-minded. Let us pool our resources, everyone paying a little into a health-insurance fund, everyone receiving in return full medical care and health services for self and family. *It is so beautifully simple—and so damnably false.*

For instance, one of the promises repeatedly made by Senators Murray and Pepper in connection with S. 1320 is that everyone would have a complete physical examination every year. A little elementary arithmetic will show the fallacy of that promise. If 125,000 practicing physicians spent their full working time of 2,000 hours a year on physical examinations for all the people, they would have less than 2 hours each to give to each person and there would be not a single physician available for anyone who was ill. The promises of the Wagner-Murray-Dingell bills and of the Federal propagandists are utterly fantastic. S. 1320, quite correctly, has been called a fraud on the American public. As a matter of fact, the Federal Government might well find itself in the position of the New Zealand Government which sold the people short by promising services it was not able to deliver. New Zealand finally said to its people, in effect: "If you can find a doctor who will treat you on the terms laid down by the social-insurance law, we will foot the bill." But it was a case of first catch your doctor.

PROPAGANDA METHODS

Now let us look at the methods employed for selling the idea of a comprehensive national social-insurance law. There has been established in Washington a well-organized propaganda machine inside the Federal Government. It is operated by Federal Security officials who openly flout Congress and daily break Federal laws by misusing Federal appropriations. They control the media for dissemination of information regarding social insurance, unmet health needs, costs of programs, etc. The Bureau of Research and Statistics in the Social Security Administration has prepared numerous reports for Senate committees. The central theme of these documents is that only through Federal "health" insurance can the health of the Nation be improved and adequate medical care be given to all the people. They have never explained by what legerdemain they expect to give to everyone all the promised services without raising the costs to prohibitive figures. Apparently they are following Hitler's advice about propaganda. He said:

"All effective propaganda has to limit itself only to a few points and to use them like slogans. * * * It has to appeal forever and only to the masses. * * * The more modest, then, its scientific ballast is, the more it exclusively considers the feeling of the masses, the more striking will be its success."

Thus the slogans of the Federal Government propaganda machine, which is financed exclusively from tax funds, and of the cooperating nongovernmental lobbies are as follows: "Health insurance is *not socialized medicine.*" "Health insurance must be *compulsory.*" "Medical services must be available as a *right.*"

FEDERAL-COMMUNIST COLLABORATION

The Federal propagandists have worked closely with the two main private lobbying groups, the Physicians Forum, whose chairman is or was a member of eight Communist-front organizations, and the Committee for the Nation's Health, which is particularly active at Senate hearings. Both of these groups use the Communist International Workers Order as an outlet for publications. Recently the Committee for the Nation's Health prepared material for a film on medical-care insurance, to be distributed by the IWO. The Social Security Administration, the Public Health Service, and the Farm Security Administration furnished pictures to the IWO for the same propaganda film strip. Publicity for the film appeared in the Communist Daily Worker on June 2, 1947.

The International Workers Order is one of the strongest and most active Communist organizations in this country. Founded in 1930, it follows the Moscow line. An essential part of its program is the establishment in the United States of a comprehensive social insurance system along the lines laid down in the Communist International. The IWO has supported each of the Wagner-Murray-

Dingell bills. The organization sent an admitted Communist to testify this summer in favor of S. 1320. The primary objective of the IWO is the overthrow of our form of government and the establishment of a Communist state. This is the organization which is aiding in the propaganda for the welfare state and which in turn is being aided by Federal officials.

This entire situation, as many of you know, is now under investigation by the Harness Subcommittee on Publicity and Propaganda. Hearings have been held in the House and one report has already been published. A large number of officials in four bureaus in the Federal Security Agency have been charged with misuse of Federal funds for the purpose of socializing medicine. The subcommittee voted unanimously to request Attorney General Clark to investigate the lobbying activities of those officials who long have endeavored to foist upon the American people an alien system of national social insurance as a prelude to establishing a welfare state under Federal control. The Department of Justice recently completed a preliminary study of the Harness hearings and charges. It was sufficiently impressed to refer the entire matter to the FBI which has started its own investigation, attention being centered on the Bureau of Research and Statistics in the Social Security Administration.

MISSION TO JAPAN

During August Representative Harness called attention to the fact that some of the same Federal officials whose activities were even then under investigation were planning to fly to Japan to sell the Wagner-Murray-Dingell bill to the Japanese. The Harness subcommittee requested that the Social Security mission to Japan be delayed pending the results of the investigation. Protests from all over the country were sent to the Secretary of War, to the Federal Security Administrator, and to General MacArthur, urging that the mission be held up. The American Medical Association offered its professional services to make a bona fide study of the health and medical needs of Japan. Nothing could illustrate more clearly how hell-bent these Government officials are on doing as they please, regardless of Federal laws and of the wishes of a congressional committee, than the complete disregard they showed for requests to delay the mission to Japan. The mission departed on August 28. The four officials who went have long been associated with the leader of the nationalization movement in the United States. The Commissioner of Social Security, Arthur J. Altmeyer, together with other Federal officials, all of whom are under investigation by the FBI, plan to proceed to Japan a little later, at the taxpayers' expense. An omnibus national social insurance bill of the Wagner-Murray-Dingell type is to be ready for the Japanese Diet by October 1 with the aid of the members of the mission to Japan. Compulsory legislation which our own Congress has refused to accept for this country may yet be foistered on the Japanese if our States do not intervene.

In the meantime the Harness subcommittee is continuing its skillful probe of the Federal Security Agency all through the summer. It has descended on the files of Social Security Administration unearthing letters and other documents which demonstrate how closely the Bureau of Research and Statistics worked with the newspaper PM, with lobbying groups, union officials, and the International Labor Organization.

These several investigations will not be completed until early in the next session of Congress. In addition, the Senate hearings on health legislation will be resumed in January. Isidore S. Falk, Director of the Bureau of Research and Statistics, will be recalled to continue testifying on his activities as leader of the nationalization movement and as the most active Federal lobbyist for compulsory sickness insurance.

For the first time it seems likely that there will be brought into the open the full story of the effort of a handful of Federal officials to grab control of vast Federal trust funds and to establish a welfare state in the United States. Until the activities of these officials are fully aired and the law has been invoked against them, there is small chance of any true cooperation between the States and the Federal Government in working out a genuine national health program.

The officials now under investigation have not inspired confidence; their reports have been discredited; the reliability of their interpretations of factual material has been challendged at the Senate hearings. Their integrity has been questioned. It is a matter of grave concern to every citizen when a Federal official fails to regard a public office as a public trust. It is a national calamity when that same official, driven by an overweening urge for power, endeavors surreptitiously to sell state socialism to the President, the Congress, and the public in the guise of legislation allegedly for the general welfare.

Dr. SHEARON. And the Blueprint for the Nationalization of Medicine, which has been inserted numerous times. This is the first time I am inserting it. There is one very slight correction which might not mean very much to outsiders, but it has been called to my attention, and since I myself am inserting the document, I wish to have this correction made in the print.

Senator DONNELL. That is, you want to introduce it now with the correction?

Dr. SHEARON. I wish to introduce it now with the correction.

Senator DONNELL. I think, inasmuch as we have these others in, we had better put this one in, too, although it is a duplication of a good deal of insertion. Could it be done by reference?

Dr. SHEARON. It could easily be done. I should like to have it so done.

Senator DONNELL. Could you describe what the correction is?

Dr. SHEARON. Yes; I can.

Senator DONNELL. I think that would be better than to insert the entire Blueprint.

Dr. SHEARON. It would be expensive and a waste of public funds for it to be printed again, and would clutter the record.

Senator DONNELL. I think so, too.

Dr. SHEARON. It is just a letter and one short word.

Senator DONNELL. Then it will be understood that the document will not be reprinted. I do not mean by that statement to indicate any hostility to the document, or lack of appreciation of its content, but in the interest of economy I think it would be well to merely describe that correction at this point.

Dr. SHEARON. It is on page 8.

Senator DONNELL. Of the Blueprint?

Dr. SHEARON. Of the Blueprint for the Nationalization of Medicine, the third printing, and it does a great injustice to Mr. Falk, and it was entirely unintentional on my part. In the text, on line 5, I state that he spent 5 years on the faculty of the Chicago Medical School. It should have been the University of Chicago. That might sound like a very small change, but in Chicago it is very significant, because the Chicago Medical School is not an accredited institution. There is a Chicago Medical School which is not accredited, it is not of high standing.

Senator DONNELL. May I inquire of the clerk whether the Blueprint has already been published in the proceedings of this committee?

Mr. RODGERS. The first, second, and third printing of the Blueprint are all to appear in volume 4, which now is in the process of being printed.

Senator DONNELL. I should like to suggest that by some appropriate note we insert with reference to that Blueprint, that attention should be called to the correction now being made by Dr. Shearon. I think the note could recite: "For correction in the above-mentioned Blueprint, see testimony of Dr. Shearon, given on May 27, 1948." It might not be practicable to give the page number of that, because you will print the Blueprint before you get to the pages of today's proceedings.

Dr. SHEARON. It could be cross referenced.

Senator DONNELL. Put it in conspicuous type, so that it will be perfectly clear to the reader that there is a correction to be made which would warrant looking for it. In fact, I think it would be only just to Dr. Falk to put in the note what the correction is.

Dr. SHEARON. Certainly the correction should be as prominent as the original statement.

Senator DONNELL. Mr. Rodgers, will you be so kind as to exercise your best judgment as to the type of note to insert? You are authorized to cause the insertion of the appropriate note, giving in conspicuous type the correction to be made, so that a person will not have to go into the proceedings of May 27 in order to find it.

Dr. SHEARON. I just learned of this error the other day. It was wholly unintentional. It was simply a short cut in language, where, instead of saying the University of Chicago, I abbreviated, saying the Chicago Medical School, not knowing that there was a substandard medical school. I would not in any way reflect on Mr. Falk's scientific training and background, because it is excellent. Certainly he had the highest exposure to the best of medical training in the field of bacteriology and science that could be offered to a person in this country.

That, of course, is one of the points that I make, that he does have this very fine background, a fine understanding of science, an excellent training. I feel that there is less excuse for a person so highly trained for not being entirely truthful and straightforward in presenting material to Congress. That is the major complaint that not only I, but other members of his staff, have had in regard to the statements that have come from that bureau, and that are misleading.

Since the reliability and trustworthiness of some statistics, reports, interpretations emanating from the Bureau of Research and Statistics and from other bureaus in the Federal Security Agency are in question and since the officials responsible for such statistics, reports, and interpretations are, or have recently been, under investigation by the Harness Subcommittee on Publicity and Propaganda of the House Committee on Expenditures, and by the Department of Justice and the Federal Bureau of Investigation, I believe this subcommittee would be justified in questioning the basic need for any legislation in the field of personal health services, at least until these several investigations have been completed and Congress has had full reports.

B. Since the broad field of social security legislation is extremely complex and since legislation therein may be referred either to the Finance Committee or to the Committee on Labor and Public Welfare, depending on whether or not taxing provisions are included in the bills being referred, it is obvious that the members of the two committees have little or no opportunity to know about what occurs at hearings or at meetings of advisory councils of the respective committees. Thus I doubt if this committee is aware of the startling proposals which Commissioner Altmeyer made before the Advisory Council of the Finance Committee on December 4, 1947, and on December 16 and 17, 1947. I doubt if this committee has followed the activities of Federal Security officials in engineering legislation through the Senate Committee on Expenditures in Government Departments.

Senator DONNELL. Doctor, there was some reference made in the hearings some months ago to a situation existing in the Japanese matter. After that reference was made, Mr. Harness delivered a public address, as I recall it in Indiana—although I am not positive of the State.

Dr. SHEARON. That is right.

Senator DONNELL. Do you know whether or not that address was placed either in the appendix or the body of the Congressional Record?

Dr. SHEARON. I am not sure. I have a copy, but I do not have it with me. I think, as a matter of fact, that it would be helpful to have it in the record. He reiterated all of his past statements in regard to the impropriety of the activities of the officials in question, and at that time he had seen a full report from General MacArthur, which has not been made public.

Senator DONNELL. I think it would be proper to insert either the entire address, or that portion applicable to the Japanese situation. My impression is that he discussed matters other than the Japanese situation in that address, and if that is correct, it is hardly necessary to encumber the record with the other matters.

Let the record show that the committee reserves the right at this point to cause to be inserted into the record, such portions as it shall deem relevant, from the address made by Congressman Harness, to which reference has been made.

Dr. SHEARON. This might be helpful—oh, I guess not. It was a summary of his statement that he released for the morning papers. It is a very short, concise summary.

Senator DONNELL. I believe it would be better, Doctor, to have what he actually said in his address.

Dr. SHEARON. It is his own press release, but I think that is true.

Senator DONNELL. Will you proceed, Doctor?

Dr. SHEARON. I was referring to this statement by Mr. Altmeyer on December 4, as an illustration of the kind of statements that this committee would probably have little knowledge of. In other words, you are busy with other things. But this preceded the present recommendations which have now come out by President Truman, and they fall very closely in line with what Mr. Altmeyer has recommended for the expansion of social security along very broad lines.

It is interesting to note that they have in mind, for instance, the way in which the social security tax can be integrated with the income tax, so that you would have an earmarked social-security tax right on your income-tax blank. They have it all worked out. It is rather interesting how forehanded they are in planning our whole financial future. This is Mr. Altmeyer's recommendation. I do not wish to insert that. I just want to show it to you as an illustration of how far ahead they are thinking on this whole plan, and that the Senate and this committee simply would have no occasion to know anything about such statements.

Since Federal officials are working on many fronts in Congress to insure enactment of bills which they have written and promoted, I recommend that a Joint Congressional Committee on Social Security be set up and that any new proposals be referred ultimately to that committee before action is taken. If such a plan is not feasible I recommend that some other arrangement directed to the same end be considered so that piecemeal social security legislation may not be approved without the fullest understanding of the position and significance of such legislation in the whole social security scheme.

C. If a Joint Congressional Committee on Social Security or some similar body be created, I suggest that its first duty be to study the desirability of repealing the Social Security Act before the Nation is entirely engulfed by the legislative program which is being promoted. If we do not save ourselves now, I believe we are headed straight for state socialism and dictatorship via a comprehensive scheme of national compulsory social security for the entire population. If the Congress fails to see the whole picture and fails to act, the Nation is in grave danger of succumbing to a dual-purpose social security program designed to tax, and tax, and tax—rule, regulate, and regiment.

Recommendation II. If the subcommittee for political or other reasons should decide that it wishes to report some bill out during this session of Congress, then I suggest consideration of the following provisions:

A. Creation of a national health agency for the purpose of bringing together the health and medical functions of the Federal Government in a single independent agency entirely free of domination by the Federal Security Agency.

I realize now, of course—I wrote this back in January—that such a proposal would be entirely impracticable this year, because Congress is not likely to act on such a change in the Governmental organization until hearing from the Hoover Commission, but I should hope that this recommendation might then be passed on to the Hoover Commission, so that there will be a realization of the necessity for removing health functions from the control of the Federal Security Agency. Such a health agency would be autonomous, deriving its powers, authority, and funds directly from the Congress. Title I of S. 545 calls for creation of such an independent agency. I believe this title should supersede S. 140 which would create a tripartite department of health, education, and security by elevating the present Federal Security Agency to departmental level. The most controversial issues in this title are found in sections 101 and 104 and relate to: (1) the qualifications of the National Health Administrator, (2) the qualifications of the Director of the Office of Medical and Hospital Care Services, and (3) the constituent units in the agency. I can furnish detailed views on these issues when and if the subcommittee decides to act on title I.

I have always thought that title was very important. It has not received much attention. But it gives a freedom to the health services that they do not now have. At the present time they are being increasingly subordinated to lay control in the Federal Security Agency, and the reorganization that is going on right now in the Federal Security Agency tends to accentuate that whole plan of subordinating the medical sciences to control by laymen.

B. Authorization of $4,000,000 for surveys of health needs, $3,000,000 for medical care survey, and $1,000,000 for dental survey. The Congress clearly should know why it is going anywhere in the field of personal health services, and if it decides to enter the field, it should know where it is going. A simples questionnaire has already been sent to the governors of the States asking for their preference between S. 545 and S. 1320. They have not shown enthusiasm for S. 1320, but perhaps if you had given them a third choice of no bill at all, they might all have voted unanimously to be let alone.

However, I think it would be generally agreed that there is real need for a bona fide, unbiased survey of the country's health needs. The National Health Survey of 1935, a WPA project, has always been suspect. The original questionnaires have been bled white during the years.

Senator DONNELL. Doctor, do you think that the Brookings report would obviate the necessity of this survey, or do you still think some such survey would be needed?

Dr. SHEARON. I think you would need some such survey. Of course, the Brookings Institution has gone into the matter very thoroughly, not, however, reporting specifically, State by State, on what they are now doing with regard to personal health services. There is a tremendous amount being done in the States. As I travel from State to State, and city to city, I see what they are doing locally.

It had been my hope, if I had stayed with the committee, to bring out that information for the benefit of the committee, so you would have an idea of what is being done voluntarily.

The people in this nationalization movement are not interested in what is being done voluntarily. As a matter of fact, I just read a statement in this 1944 ILO report on this very subject. I will not take the time to hunt it up now. It says that they do not consider things that are being done on a voluntary private basis, but that their whole program is directed to what is being done by governments.

I think it would be a good idea if we followed our own plans and found out what we are doing on a private voluntary basis, instead of saying that the only thing we are interested in is what other governments are doing.

This is a field in which many persons think the job can be done a great deal better on a private voluntary basis. And perhaps you ought to keep it very largely on a local level. If we are to have such a survey, as proposed in S. 545, and if it could be an honest-to-goodness survey, it might be valuable. However, I might say that I have grown very skeptical about surveys, because the wrong persons get hold of them. When you know who is running the survey, the reports that come out are exactly what might have been expected. You therefore do not get any new information and interpretations are unreliable.

I think this: I am not too anxious for any survey, but if any legislation is to be offered of any type in this field, I think we ought to know why the Federal Government thinks it is necessary to enter the field of personal health services, if there are real needs, and if the Federal Government should get into the job at all.

We need an objective, fact-finding survey not designed to prove anything, but to get at the truth about the condition of the Nation's health. Many States have completed hospital surveys and would now be ready to round out the picture by surveying medical and dental needs. The reports from the States should not go to the Federal Security Agency as now constituted.

I feel if we turn over the survey findings to the Social Security Administration and if the Congress should ask them for an analysis, it has been demonstrated in the past that you cannot trust their analyses and interpretations. So, even if you had perfectly good facts, you would not get an honest interpretation of the needs from that agency. A group entirely independent of the Federal Security Agency would be very desirable to do the analytical work. Indeed, they, the reports, might be forwarded directly to this subcommittee for study and analysis, although that would involve utilization of a larger staff than is now available.

C. Action on titles VII and VIII of S. 545 to be deferred until completion of surveys. If the subcommittee should decide not to defer action on these titles, then I would urge sharpening of the language of section 712 (4) which deals with use of Federal funds for payment of premiums to voluntary, nonprofit medical, hospital, or other insurance funds. The purpose of this section was to stimulate the voluntary insurance movement. The section would, however, create friction between nonprofit and profit insurance funds and might lead, through subsidy, to an unfair interference with the private insurance industry. I think, too, it is well to realize that voluntary insurance, if it becomes too large, will not only tend to take on the characteristics of governmental insurance, but may open up the way to capture by the Federal Government. Voluntary sickness insurance has ever been the precursor to compulsory sickness insurance.

That is a very important thing to realize. I am worried about an inclusion in S. 545 of funds designed to stimulate voluntary plans. I did not oppose it at the time. I actually helped in drafting it, but as I have made more and more inquiry out in the field, I see the dangers of having the Federal Government pour perhaps large sums into these voluntary plans, because wherever you put Federal funds, you put Federal controls and regimentation. The voluntary plans would, of course, with such stimulation, grow larger, but they would also grow nearer to a compulsory plan, on a Nation-wide basis, and pretty soon I think we would have persons urging that the Federal Government take over the voluntary plans.

I have referred here to the competition with the private insurance industry. There is very strong feeling against the giving of Federal moneys to the nonprofit insurance funds like the Blue Cross and other voluntary plans, and shutting out the private insurance industry, which certainly at times is able to provide an even cheaper policy than the Blue Cross.

It is a very controversial issue. It is a difficult issue to decide, and I am not prepared to recommend one way or the other, but I think it should be considered as to what you are doing when you put money into stimulating some part of the economy, if it is the proper thing to do.

I should like to read just a very short paragraph from Mr. Falk's Medical Care Insurance, of 1946, which has been referred to before, in which he starts out with this statement: "Compulsory health insurance is the oldest form of social security. After long experience with voluntary insurance, compulsory insurance began in Central Europe with the German legislation of 1883." He points out there very clearly that you begin with the voluntary plans, and then you go over into the compulsory. It is a point I have made, and I think we should consider very carefully, as to what we are doing, if there is too much stimulation of the voluntary plans. Why not let them grow as they want to. I do not see any reason for forcing everyone in the country to get into some kind of insurance scheme if they do not want to get into it.

There is another danger to be guarded against in title VII. If the program for medical care for the low-income groups were to be administered by State health departments, there would be considerable likelihood that the influx of large sums of Federal money would so increase the power of those departments, especially in the larger States, that they might set up State funds and develop compulsory insurance programs. Such a development would not necessarily mean that the States desired compulsory insurance, but that active, powerful minorities in official State agencies were proceeding at the State level, just as such minorities have proceeded at the Federal level.

In other words, if we turn over—if the Congress should turn over large sums of money to State agencies for providing medical care for those who cannot afford it, and you do not say how you are going to determine who cannot afford it, then those State health agencies might very well say they were going to use such funds to develop a compulsory insurance scheme. It might not mean that the people of the State would want such legislation, or such schemes developed, but you could through an active, organized group of State officials have the same sort of thing done in a State that we now see going on at the Federal level. I think that should be very clear. I am trying to point out some of the dangers that are inherent in S. 545, so that you may consider whether or not even that bill is a desirable bill.

D. Authorization of funds for expansion of public health services as proposed in Title III of S. 1320. I believe that if Congress wishes to spend money for improvement of national health, it could do no better than increase the appropriations of the Public Health Service for work in the field of preventive medicine. You are likely to get a better return on your money if you spend it on stamping out disease than if you pour it out on an enormous, complex, and uncertain system of social insurance.

Earlier this week, we heard a plea from the Gorgas Memorial group asking for very small sums of money to do a tremendous amount of good in the field of preventive medicine. If Congress has money to spend, I am sure that is the way to spend it.

E. Limitation of grants-in-aid, except for surveys and public health services, to States which are definitely in need and which seek Federal funds. Most of the clamor about the "needs" of the "poor" States seems to come from Washington, rather than from the States themselves.

I doubt if you have been besieged by a large number of States, asking you to step into this field of public medical care financed by public funds. This is initiated in Washington, and does not come from the grass roots.

F. Deferral of action on bills for school health services until States have reported on their needs and wishes.

That is the end of my recommendations. I have two other things that I would like to do. One is to discuss briefly, to bring together the information on the two nongovernmental lobbying groups, and then after that to give you a brief statement on the legislative history of the compulsory insurance bills. We have not had that in the record. It is extremely important to realize for future use.

The most important of the nongovernmental lobbies is the Committee for the Nation's Health, Incorporated, which has its main office in New York, at 1790 Broadway, its Washington office at 914 G Place NW. The Washington representative is Margaret I. Stein, who has appeared at most of these hearings. Another Washington representative is William G. Reidy, who for a part of this year has been on the payroll of the Committee for the Nation's Health, at $6.500 a year, and is registered as a lobbyist for the enactment of the Wagner-Murray-Dingell bill, and the rest of the time he has been sitting at your left with Senator Murray.

The Committee for the Nation's Health has as chairman, Channing Frothingham, and the chairman of the executive committee is Michael M. Davis.

I should like to introduce into the record—it is a rather long thing, yet I think it might be valuable to have just the names of the persons who are working with the Committee for the Nation's Health. They are all printed right here on the document. I am trying to think of the best thing to do, whether to pick out a few of the names. They are on the front and on the back. They are the names that have appeared over and over. Perhaps I could select a few, without giving all of them.

The significance of these names is that they appear over and over in connection with different committees that are formed. Some of them appear again and again in communist-front organizations as an interlocking directorate type of organizational set-up among these various committees, both the Communist committees, and the Committee for the Nation's Health. That is indicated by the membership of certain persons in this committee, and in numerous other committees.

(At this point Dr. Shearon submitted her list as referred to in her testimony as follows:)

Partial list of members of two nongovernmental lobbying groups and of invited delegates to the National Health Assembly, Inc., May 1–4, 1948

Name	Committee for the Nation's Health, Inc.	Physicians Forum, Inc.	Invited delegate to National Health Assembly, Inc.	Member, executive committee NHA, Inc.
Louis Adamic	X			
Thomas G. Addis, M. D	X		X	
Alfred J. Asgis, D. D. S	X		X	
Mary McCleod Bethune	X			
Barry Bingham	X			X
Ernst P. Boas, M. D	X	X	X	
J. Douglas Brown	X		X	
Allan M. Butler	X	X	X	
Morris Llewellyn Cooke	X		X	
John Corson (the Washington Post)	X			
Norman Corwin	X			
Jonathan Daniels	X			
Russell Davenport	X			
Jo Davidson	X			
Michael M. Davis	X		X	
Channing Frothingham, M. D	X	X	X	
Franz Goldmann, M. D	X	X	X	
William Green	X			
Sidney Greenberg, M. D		X	X	
Helen Hall	X		X	
Quincy Howe [1]	X			
Paul Kellogg	X			
Mary D. Keyserling	X			
Harold Koppelman, M. D		X	X	
Albert D. Lasker	X			
Mary W. Lasker	X			X
Leo J. Linder	X		X	
Bishop Francis J. McConnell	X			
J. Howard Means, M. D		X	X	
Lowell Mellett (the Washington Post)	X			
Gerald Morgan	X			
Philip Murray	X			
Bishop G. Bromley Oxnam	X			
John P. Peters	X	X	X	
Martin Popper	X			
Mrs. F. D. Roosevelt	X			
Mr. James Roosevelt	X			
Anna M. Rosenberg	X			X
Lessing J. Rosenwald	X			
David Sarnoff	X			
Theodore Sanders, M. D		X	X	
Fred M. Stein	X			
Gerard Swope	X			
R. M. Walls, D. D. S	X			
Walter Wanger	X			
Edwin E. Witte	X			
Matthew Woll	X		X	

---

[1] Radio commentator and final summarizer for National Health Assembly, Inc.

Ernst P. Boas is a particularly good illustration. He is a member of the Committee for the Nation's Health. He is the chairman of the other lobbying group, the Physicians Forum. And then he is a member of a number of communist-front organizations.

Senator DONNELL. How many?

Dr. SHEARON. Eight communist-front organizations. I think I commented on that when I spoke of the Physicians Forum. Perhaps it might save space and time if I selected just a certain number of the names from this list, and had those inserted in the record. Would that be satisfactory?

Senator DONNELL. Very well. Will you make the selection, and give them to the reporter? Are any of those persons on the Committee for the Nation's Health or the Physicians Forum, members of the Institute of Public Affairs?

Dr. SHEARON. I do not have that membership, but I think when you mentioned that this morning, you mentioned also the Committee on Research and Medical Economics. Did you not mention two things this morning? You mentioned the Committee on Research and Medical Economics. The Committee on Research and Medical Economics is, of course, the Mike Davis committee that was set up with funds given to him when he left the Rosenwald fund in 1936. They gave him a sum of money, and he set up this committee. I think the correct date is 1936. I have that date in my Blueprint. That is the committee that published this lobbying document in collaboration with the Federal officials I have just named.

Senator DONNELL. The one entitled "Principles of a Nation-Wide Health Program?"

Dr. SHEARON. That is right. In what connection was this, that they were to do what—this committee is to do what? Oh, yes——

Senator DONNELL. It was mentioned in Senator Murray's letter to Senator Smith.

Dr. SHEARON. Yes. Well, then, in view of that fact, it might be well to have some other kind of a report prepared that would not so obviously come from a biased source. In other words, if you had it coming from a lobbying organization, I do not see that you would get, shall we say, a research document.

These two groups, that is, the Physicians Forum and the Committee for the Nation's Health, have worked together right along, the Physicians Forum being composed entirely of physicians, whereas the Committee for the Nation's Health is composed of both physicians and lay persons.

There is noticeable in this list of members of the Committee for the Nation's Health a pronounced interlocking with the membership in the Physicians Forum, to the extent that that is possible. The Physicians Forum would be exclusively physicians, but such men as Allan Butler, Thomas G. Addis, Ernst P. Boas, are all physicians, and are members of both groups.

It is interesting to note here that Barry Bingham, one of the top 24 persons selected in the National Health Assembly, is also a member of the Committee for the Nation's Health. As I say, I have not completed my analysis of the connections of these people who were named on the Committee on the Nation's Health.

Anna Rosenberg was picked for that top committee of the National Health Assembly, Inc. She is a member of the Committee for the

Nation's Health. She was for many years with the Social Security Board.

So that these inter-relationships of these people is very important, with the comparatively small size of the groups. For instance, the Physicians Forum has been in existence for 10 years, and has only about 1,000 members, even now, and two-thirds of those are from New York, as you yourself brought out in earlier testimony. I might say Mrs. Roosevelt is honorary vice president of the Committee for the Nation's Health.

This Committee for the Nation's Health has been very active in publishing a great deal of material. For instance, one of the things they put out was Health for the Nation. It includes a number of so-called facts, and it is extremely misleading. This was put out in 1946. I will just quote one of the "facts": "Nothing short of passage of the Wagner-Murray-Dingell bill will provide for the Nation's health needs." I do not think it has been proven, and I do not think it is a fact. But that is the kind of thing that is put out. And the committee derives its support, did derive it from the Rosenwald fund, which is now exhausted. There is the Adele [Rosenwald] Levy Fund, which is not exhausted, and the Milbank fund, which has been supporting Mike Davis for years.

There are always, seemingly, plenty of funds to put forth money for this nationalization movement. I do not question the motives of people who put up the money. I believe they do not know what they are putting it up for. We had Mr. Lasker here, and it was obvious to everyone that he had no notion of what his money was being used for. He left the room before illuminating cross examination of Michael Davis would have revealed what Mr. Lasker's money was being used for.

Now, coming to the Physicians Forum, I should like to refer to a dinner that was given on April 11, 1946, for fund-raising purposes. It was given at the Waldorf-Astoria, and at the speakers' table were, among other persons, Dr. Ernst P. Boas, the chairman of that committee; Nelson Cruikshank, Michael M. Davis, Representative John Dingell, Dr. Channing Frothingham, Dr. Sidney W. Greenberg, the secretary of the Physicians Forum, Mr. Leon Henderson, who has testified here in favor of the Wagner-Murray-Dingell bill, Senator Murray, Dr. John P. Peters, and others.

Now, among the persons who were seated at the various tables—they are all listed—was a Dr. Leona Baumgartner, who, again, was one of those selected by Mr. Ewing, either for the top committee, or for one of the chairmanships of one of the committees. I will give you that information. I forgot to look it up.

(Subsequently Dr. Shearon stated that Dr. Baumgartner was named chairman of the Maternal and Child Health Committee of the National Health Assembly, Inc.)

The International Workers Order had a table. That order, we have seen, is one of the most powerful Communist groups in the country working for the overthrow of this Government. It has worked with the Committee for the Nation's Health, and with Dr. Boas.

I want in this summary to point out that the Committee for the Nation's Health prepared a document entitled "Medical Care Insurance" for the Film Branch of the International Workers Order, and in that document there was an expression of thanks for the assistance that had been given by the Committee for the Nation's Health, and a recommendation that persons who wanted more information should go either to the Committee for the Nation's Health or the Physicians Forum.

I think it is significant that these two lobbying groups are working with a Communist group, and using the facilities of the International Workers Order for the distribution of material.

Also at that dinner, which was sponsored for the purpose of raising funds to promote the Wagner-Murray-Dingell bill, the tickets being $7.50, were persons like Mr. and Mrs. Paul Kellogg, who have long been associated with Michael M. Davis, and a number of unions. Mr. Falk brought in representatives of those same unions at a meeting which he held in December 1946 to indoctrinate the representatives of 37 labor unions as to the way in which they should consider the two bills then pending before Congress—the Taft-Ball-Smith bill—you had not come in on that bill—and the Wagner-Murray-Dingell bill. So that there was this tie-in between these labor unions which had sent their representatives to this Physicians Forum dinner, and who were then invited subsequently by Mr. Falk to attend an indoctrination meeting in a Federal agency.

Now, I have here copies of some newspaper clippings, showing, again, the way in which the nongovernmental and governmental lobbies have worked together. Here is one from the Evening Star of June 7, 1946, right while we were having hearings on the Wagner-Murray-Dingell bill. They held a meeting of the Washington chapter of the Physicians Forum, to discuss the Wagner-Murray-Dingell bill. Present at that meeting were Dr. W. P. (Palmer) Dearing, Assistant Chief of Personnel of the United States Public Health Service. He has just within the past few weeks been made the Deputy Surgeon General of the United States Public Health Service, to replace Dr. Crabtree, who held that position under Dr. Parran. Dr. Dearing was at this meeting of the Physicians Forum. Also at that meeting was Dr. Milton I. Roemer, member of the Public Health Service, and a nominee for the national council of the Physicians Forum. He later won election to that council, and his name has appeared and may still appear on the letterhead of the Physicians Forum, this lobbying group. Here, then, we have the name of a Federal official on the letterhead of a group dedicated to the enactment of the Wagner-Murray-Dingell bill.

At that meeting on June 7, 1946, Dr. Roemer, who is an M. D., stated, according to this article in the Star:

> The main problem to be faced now is one of the economic side of the profession. Advocating the passage of such legislation as the Wagner-Murray-Dingell bill to provide compulsory health insurance, Dr. Roemer said the measures would be much to the best interests of the doctors. "The National Health Act would neither put doctors on a salary or on an 8-hour day," he said, "and it wouldn't interfere with their right of private practice." He estimated that the average income of all doctors under the program would be $9,000 a year.

I think it would be a good idea to submit this entire clipping for the record. I have read a part of it. But it goes right on with further discussion by this public health official regarding the Wagner-Murray-Dingell bill.

Senator Donnell. It may be received and incorporated in the record.

(The clipping referred to follows:)

[The Evening Star, Washington, D. C., Friday, June 7, 1946]

WAR DOCTORS' WORRIES DISCUSSED AT MEETING OF PHYSICIANS' FORUM

Lack of residencies, adequate training and availabilty of surplus equipment were called the chief problems facing doctors returning from service with the armed forces at a discussion meeting last night of the Washington Chapter of the Physicians' Forum.

Dr. E. Richard Weinerman, veteran of a mobile surgical unit with the Third Army and chairman of the Health Subcommittee of the American Veterans' Committee, said that most doctors still in service are worried about the same things.

"The younger men are looking for residency appointments in hospitals and refresher training," he said, "and the larger groups—the older doctors, are worried about rebuilding their old practices, getting surplus equipment and obtaining housing and office space.

PROGRAMS INADEQUATE

"The hospital appointments we wanted weren't waiting for us, and the retraining programs aren't adequate," he said. Charging that "large amounts of surplus materials that could be put to good use" have not been made available, he called on groups of the profession and Federal agencies to "sit down and take stock of the needs and opportunities, and then act on them."

Concerted action to aid the veterans also was recommended by Dr. Palmer Dearing, assistant chief of personnel of the United States Health Service. He also cited the "desperate need" of making service by doctors attractive in poorer areas of the country, "where opportunity for many younger physicians is being lost."

Speaking of increased group practice, Dr. Dearing said citizens in some areas have banded together to guarantee income for doctors. "One issue that should be decided is whether the drive toward specialization is really to the best interest, or whether it should be routed along group lines," he said. He also pointed to the "increased interest" by labor in health measures, citing the United Automobile Workers' Health Institute at Detroit, a diagnostic and health education center for workers.

"Public health programs in education and opportunities in research and other special fields are being expanded, Dr. Dearing declared, but he said one field of education—school health programs, "has hardly been touched."

Dr. Milton I. Roemer, member of the Public Health Service and nominee for the National Council of the Physicians' Forum, said, however, that "the main problem to be faced now is one of the economic side of the profession." Advocating passage of such legislation as the Wagner-Murray-Dingle bill to provide compulsory health insurance, Dr. Roemer said the "measures would be much to the best interests of the doctors. The National Health Act would neither put doctors on a salary or on an 8-hour day," he said, "and it wouldn't interfere with their right of private practice." He estimated that the average income of all doctors under the program would be $9,000 a year.

The bill calls for a 3 percent pay-roll deduction, half to be paid by the employe and half by the employer, with small amounts from Federal revenues to finance the program. "Of interest to young physicians," Dr. Roemer said, "is the plan that 2 percent of the funds collected would be used for subsidizing medical education and research activities."

SEE FEW ABUSING PRIVILEGE

He estimated that less than 5 percent of the doctors' time under the program would be taken up by persons abusing the privilege of free care. Offsetting all arguments against the plan, according to the speaker, would be the "large numbers of Americans who would have care available for the first time."

"Far more illness and death occurs from patients not seeing doctors often enough, or soon enough, than from those who see doctors too much," he asserted.

The forum, presided over by Dr. Anna Rand, chapter chairman, was held at the YMCA, Seventeenth and K Streets NW.

Dr. SHEARON. In January of that year, 1946, when it was known we would undoubtedly have hearings on the Wagner-Murray-Dingell bill, that is, S. 1606, the lobbies were active. I have here three clippings about things that happened toward the end of that month. One item is headed: "Physicians Forum plans open meeting Saturday."

It was announced that at that meeting Nelson Cruikshank would discuss social insurance activities of the A. F. of L., that he would discuss needs for health insurance; that Representative Biemiller of Wisconsin, who has testified here in favor of the Wagner-Murray-Dingell bill, would discuss the bill. It was stated that leading the round table discussion would be Dr. Fred Mott of the Farm Security Administration, who was one of the signers of this Principles of a Nation-wide Health Program, which was issued in November 1944, by this Committee on Research in Medical Economics. Dr. Mott at that time was with the Farm Security Administration, on loan from the Public Health Service. He has now gone to Canada, where he is running the socialist plan for medical care in the Province of Saskatchewan. Also named as one of those leading the round table discussion was Harry Becker, whose name has often come up in this committee. He was then in the Children's Bureau of what was then the Labor Department. He then came over with the Children's Bureau when it was brought over to Federal Security. They brought him into the Social Security Administration. This same Harry Becker, who on January 20, 1946, attended a meeting sponsored by the Physicians Forum to discuss the forthcoming health legislation, left the Social Security Administration in February 1948, and has gone with the United Automobile Workers, in their social security department. And he was the spokesman on this nine-man steering committee of the medical care section of the National Health Assembly. He spoke for the entire CIO. He has been working with them for a long time, and now has left the Government, as a number of these other persons have. On leaving the Government, such persons have gone in with the labor group with which they had been working while they were in the Government.

At that meeting, also, Miss Margaret Klem, of the Social Security Board, was scheduled to appear. She did not appear. Her place was taken by someone else from the Social Security Board. It is mentioned here at the end of this article—and I quote: "Dr. Ernst Boas is president of the forum, whose program is to promote passage in Congress of the national health program." Yet it has been stated that these are not lobbying activities by Federal officials. I introduce this statement into the record as proof that lobbying activities have been carried on, and that these persons were in the employ of the Federal Government at the time they were carrying them on.

Senator DONNELL. You are offering this clipping?

Dr. SHEARON. I think I will introduce these three clippings. They are on the same subject. There is one here entitled "Doctors to hold first conference on national health." This is in regard, again, to a meeting of the Physicians Forum, and it was described by the Washington Post. It is a clipping comparable to the one from the Sunday Star at that time.

Then a week later after this meeting was held, there appeared this article in the Washington Post of January 27, 1946, "Health plan pressure unit is organized." This was the outgrowth of the meeting I have just described. This article states:

> A group to sell the District and Congress on compulsory health insurance was formed yesterday at a meeting of the Physicians Forum, District chapter.
>
> Local doctors, labor, and Government representatives, and lay people who indorsed national health legislation signed up as charter members of the unique "continuing committee."
>
> This organization will carry on education work for the national compulsory health program, act on specific legislative matters as they arise, and pressure Congress—

I think they have been doing that very successfully ever since that time—

> Dr. Anna Rand, Forum and committee chairman, declared.

I need not read the whole quotation, but I should like to have the whole thing inserted in the record here. It refers here to Margaret Stein, and then it states:

> Charging that the American Medical Association was "blocking" the Wagner-Murray-Dingell compulsory health insurance legislation, Representative Andrew J. Biemiller (Democrat, Wisconsin), urged proponents of the bill to step up their propaganda—

I see he calls it propaganda. That is an interesting admission.

> to counteract the "steady flow" of AMA-sponsored literature reaching Congressmen. Biemiller said the President's health program was "not a good example of Communism, but an accepted American principle." Workers are insured against old age, unemployment, and industrial accidents. Protection against illness is the next step.

I ask permission to insert the three clippings in entirety.

Senator DONNELL. The three clippings will be received and incorporated in the record at this point.

(The clippings referred to follow:)

[The Sunday Star, January 20, 1946]

PHYSICIANS FORUM PLANS OPEN MEETING SATURDAY

The District Chapter of the Physicians Forum will hold a public conference and round-table panel discussion from 9:30 a. m. to 1 p. m. Saturday at Pierce Hall, Fifteenth and Harvard Streets NW., it was announced yesterday.

Nelson Cruikshank, director of social insurance activities of the AFL, will discuss "Needs for Health Insurance," and Representative Biemiller, Democrat, of Wisconsin will discuss "The bill that meets those needs."

Leading the round-table discussion will be Dr. Fred Mott of Farm Security Administration, Agriculture Department; Harry Becker of the Labor Department's Children's Bureau, and Miss Margaret Klem of the Social Security Board. The Rev. Francis McPeek, director of the Department of Social Workers for the Washington Federation of Churches, will be chairman. Dr. Ernst Boas is president of the forum, whose program is to promote passage in Congress of the national health program.

[The Washington Post, Sunday, January 20, 1946]

DOCTORS TO HOLD FIRST CONFERENCE ON NATIONAL HEALTH

The D. C. Physicians Forum will hold the first in a series of conferences on the national health program at Pierce Hall, Fifteenth and Harvard Streets, NW., next Saturday, from 9:30 a. m. to 1 p. m.

Chairman of the first conference will be the Rev. Francis McPeek, director of the department of social welfare, Washington Federation of Churches. Representative Andrew J. Biemiller (Democrat, Wisconsin), and Nelson Cruikshank, AFL director of social insurance, will discuss President Truman's recommendations for a Nation-wide health insurance program.

A panel composed of Dr. Fred Mott, of the Farm Security Administration, Harry Becker, Children's Bureau, and Margaret Klem, of the Social Security Board will hold a round-table discussion following the speeches.

[The Washington Post, January 27, 1946]

Health Plan Pressure Unit Is Organized

A group to sell the District and Congress on compulsory health insurance was formed yesterday at a meeting of the Physicians Forum, District chapter.

Local doctors, labor and Government representatives, and lay people who endorsed national health legislation signed up as charter members of the unique "continuing committee."

"This organization will carry on education work for the national compulsory health program, act on specific legislative matters as they arise, and pressure Congress," Dr. Anna Rand, Forum and committee chairman, declared.

Elected to the group's steering committee were Dr. Dorothy Ferebee, Dr. Irving Winik, Dr. Rand, the Rev. Francis McPeek, director, Department of Social Welfare, Washington Federation of Churches; Benjamin Asia, National Lawyers Guild, District chapter; and Miss Margaret Stein, medical economist.

Charging that the American Medical Association was blocking the Wagner-Murray-Dingell compulsory health insurance legislation, Representative Andrew J. Biemiller (Democrat, Wisconsin), urged proponents of the bill to step up their propaganda to counteract the steady flow of AMA-sponsored literature reaching Congressmen.

Biemiller said the President's health program was not a good example of communism, but an accepted American principle. Workers are insured against old age, unemployment and industrial accidents. Protection against illness is the next step.

Dr. Shearon. I have a clipping dated March 8, 1946, from the Washington Post. The heading is "Health plan to cover everyone in Nation urged by Dr. Parran." A meeting was called under the auspices of the Physicians Forum by the District chapter of the National Lawyers Guild, which has, as you know, testified in favor of the Wagner-Murray-Dingell bill. These two groups sponsored a meeting that was held in the auditorium of a Government building, the Archives Building.

The speakers were Dr. Parran, then the Surgeon General of the Public Health Service, and Isidore S. Falk, director of the Bureau of Research and Statistics, along with Robert K. Lamb, legislative representative of the United Steelworkers of America, CIO.

I think it would be well to have in chronological order in the record this clipping, also.

Senator Donnell. It will be received and incorporated in full in the record.

(The clipping referred to follows:)

[Washington Post, March 8, 1946]

Health Plan To Cover Everyone In Nation Urged by Dr. Parran

Calling for a national health program "accessible to everyone regardless of his ability to pay," Surgeon General Thomas Parran of the Public Health Service, last night said he believed it could not be done on a voluntary basis.

Pointing out that at present about 40 percent of the people in counties throughout the country cannot avail themselves of modern medical facilities, Dr. Parran predicted increasing Federal concern in the matter of health.

Already, he said, the PHS had broad authority to act as a national scientific foundation which enabled the Government to enter into the field of medical research.

> Declaring that "prepayment of medical costs is important," Dr. Parran said he believed a method of spreading costs of medical care should be found.
>
> About 10 years ago, Dr. Parran said, the American Medical Association was against a national health program either compulsory or voluntary. Now, he said, the AMA has declared itself in favor of a voluntary program.
>
> His remarks were made to about 200 who attended a meeting in the Archives Building auditorium sponsored by the District Chapter of the National Lawyers Guild.
>
> Dr. Isadore Falk, director of the Bureau of Research and Statistics, Social Security Board, and Robert K. Lamb, legislative representative, United Steelworkers of America (CIO), also addressed the meeting.

Dr. SHEARON. I am afraid I have not given these in the best chronological order, but, at any rate, I think this should be in the record. It is a letter from the Physicians Forum dated August 27, 1945, and it refers to a copy of a summary of the provisions of the Wagner-Murray-Dingell bill, and then goes on to say:

> The Physicians Forum is also prepared to assist you or any organization interested in promoting passage of the Wagner-Murray-Dingell bill, by furnishing press releases for local newspapers, recommending speakers for conferences or mass meetings, and in other ways. We hope that you will call on us for help.

Now, on November 15, 1945, Dr. Ernst P. Boas presided at a membership meeting of the Physicians Forum at the Hotel Lombardy, 111 East Fifty-sixth Street, New York City. He spoke first on the increase in membership they had had, and then called for the treasurer's report. At this point I should like to make a correction in the testimony of a little while ago. in which I stated that Sidney M. Greenberg was the secretary of the Physicians Forum. I should well have remembered that he is the treasurer. I quote here directly from the minutes:

> Dr. Sidney M. Greenberg stated that the special grant of $10,000 had been given to the Forum for the promotion of the Wagner-Murray-Dingell bill. It has enabled us to add office staff. The major part of this fund has already been spent. This grant was specifically for work on this legislation, and has not been used for general activities.

Then Dr. Boas went on to say that in addition to this grant they had also received another grant in the form of $1,500, which enabled them to print 50,000 copies of the pamphlet "For the People's Health." Forty-nine thousand of these copies had already been distributed, and the C. I. O. bought 5,000; the A. F. of L. 10,000 copies; the Northern California Union Health Committee purchased 5,000 copies.

It is a lobbying document. I shall not introduce it in the record. I have a copy. But it is decidedly a promotional document.

The Physicians Forum has continued these activities to date, and for the same purposes, and yet it has not registered either with the clerk of the Senate or the clerk of the House, as a lobbyist, and I think that matter should be referred to the Department of Justice for prosecution.

I should like to introduce into the record the names of the eight Communist-front organizations with which Dr. Boas has been or still is affiliated.

Senator DONNELL. How do you know they are Communist-front organizations?

Dr. SHEARON. This is all taken from the reports of the Committee on Un-American Activities, and is documented from those reports, which were published in 1944. I believe that it is of sufficient significance to the American people to have this entire statement incorporated. I have selected from these reports the gist of what they have stated with regard to Dr. Boas and his connection with these various organizations, and the purposes of the organizations, and because of the persons with whom he has been associated in these Communist organizations, and their tie-in with the Committee for the Nation's Health, and with the National Health Assembly, Inc., I think we should have this spelled out in detail. I have the page references to those reports, so that it is a fully documented record.

Senator DONNELL. You are offering that at this time?

Dr. SHEARON. I am offering that, yes. I might say that such things as this are significant: that one of the groups that Dr. Boas was a member of, called the Friends of the American Lincoln Brigade, it is stated, raised funds primarily for the benefit of the Communist Party, and that on the list of sponsors was Jacob Fisher, whose name has come up repeatedly. He now holds one of the top positions on Mr. Falk's staff, and he was associated with Boas in this Communist-front organization.

Senator DONNELL. This compilation will be received and incorporated in the record in full.

(The paper submitted by Dr. Shearon is as follows:)

BOAS' AFFILIATIONS WITH COMMUNIST ORGANIZATIONS

Boas has been a member of at least eight Communist-front organizations which have been organized by members of the National Citizens Political Action Committee. The same names appear over and over in these committees and include, beside Boas, his late father, Franz Boas, Peter Shipka, Rockwell Kent, Henry E. Siegrist, M. D., Max Lerner, George Soule, John Peters, M. D., and numerous others. Boas is, or has been, a member of the following organizations:

1. AMERICAN COMMITTEE TO SAVE REFUGEES (356) [1]

This is one of the numerous interlocking refugee aid committees which stem largely from the Communist-controlled Medical Bureau and the North American Committee to Aid Spanish Democracy. Among these committees were:

American Rescure Ship Mission.
Spanish Refugee Relief Campaign.
American Women's Committee for Spanish Refugees.
Musicians Committee to Aid Spanish Refugees.
Refugee Scholarship and Peace Campaign of the American League for Peace and Democracy.
American Committee to Save Refugees.

The House reported that as soon as one of these committees was publicly exposed as a Communist-front another was quickly set up. Earl Browder, general secretary of the Communist Party, openly urged support of these combined efforts in his report to his national committee on November 16, 1940.

Luis Araquistain, former Ambassador to France for the Spanish Republic, described the operation of the Emigration Service for Spanish Refugees (S. E. R. E.), with which the American Committee to Save Refugees was interlocked, as follows:

"The S. E. R. E. has its headquarters in Paris and a branch in London * * * the S. E. R. E. * * * particularly favors the Communist Party leaders * * * It is the C. P. (Communist Party.—Ed.) members almost exclusively, who draw the benefits of the military subsidies * * * The S. E. R. E.'s partisanship is most apparent in the way in which it manages emigration to Mexico and Chile * * * Whoever is neither a Communist nor a supporter of the Negrin group doesn't even get inside the Chilean or Mexican embassies."

---

[1] The number in parentheses refers to pages in the House Committee print, appendix IX, Communist-Front Organizations, with special reference to the National Citizens Political Action Committee. This report was published in 1944 by the House Committee on Un-American Activities.

Associated with Boas on this committee was Rockwell Kent, who is vice president of the International Workers Order.

2. AMERICAN FRIENDS OF SPANISH DEMOCRACY (382)

Among the members of the NCPAC who are affiliated with this organization, in addition to Boas, were Max Lerner, editor of P. M., George Soule, and on the professional committee of this organization were Thomas Addis, M. D., John P. Peters, M. D., Henry R. Siegrist, M. D.

3. COORDINATING COMMITTEE TO LIFT THE EMBARGO (666)

The NCPAC members affiliated with this committee include, beside Boas, Max Lerner, George Soule, Paul Robeson, Reinhold Niebuhr. On the various committes of the organization were Drs. Addis, Peters, and Siegrist, and Max Yergan. Yergan is executive secretary of the International Committee on African Affairs and is national president of the National Negro Congress which the Attorney General has branded as Communist and subversive. He has followed the Communist Party line in all of its defense based on the party's strict loyalty to the Soviet Union's foreign policy.

4. COUNCIL FOR PAN-AMERICAN DEMOCRACY (672)

Among the NCPAC members cooperating with this organization in addition to Boas, are: Max Lerner, George Soule, and the late Sidney Hillman. The conference of this council was held on December 10–11, 1938, at Washington. David Efron, former research associate to Prof. Franz Boas who was instrumental in floating scores of Communist-front organizations, initiated the gathering in the name of the conference's sponsoring committee. The purpose of the conference was to send delegates to a Communist-inspired Latin-American Congress of Democracies at Montevideo, March 20–24, 1939. A statement signed by Earl Browder for the Communist Party of the United States, together with the representatives of the Communist Parties of Canada, Chile, Cuba, Mexico, and Venezuela, called attention to the participation of the council for Pan-American Democracy in the Montevideo meeting and declared that these parties "lent their warm and sustained collaboration, and their work was an important contribution to the success of the Congress" (Communist, July 1939, p. 625).

Among those supporting the council are a number of individuals who are supporting the Communist Party, including Langston Hughes and Rockwell Kent. Others sponsoring the council have a record of long and active collaboration with Communist-front organizations. They are Maxwell Stewart, Isobel Walker Soule, Max Yergan, Vito Marcantonio, the late Franz Boas and the late Sidney Hillman (673). One of the delegates to the council was Bernard Stern, who was one of the revolutionary writers. Stern, it will be recalled, had figured earlier in calling a Congress of American Revolutionary Writers on May 1, 1935, at which time he signed a statement which included the following:

"The capitalist system crumbles so rapidly before our eyes that, whereas 10 years ago scarcely more than a handful of writers were sufficiently far-sighted and courageous to take a stand for proletarian revolution, today hundreds of poets, novelists, dramatists, critics, short-story writers and journalists recognize the necessity of personally helping to accelerate the destruction of capitalism and the establishment of a workers' government" (656).

5. FRIENDS OF THE ABRAHAM LINCOLN BRIGADE (750)

NCPAC members affiliated with this organization include Boas and Langston Hughes. One of the campaigns for funds launched by this brigade had a list of sponsors including Jacob Fisher, who later was employed by Falk at the Social Security Board and who has frequently been cited for his un-American activities. Falk has been trying to send him to New Zealand to study health insurance and to come back with the right answers. Also sponsoring the drive for funds were: Langston Hughes, John A. Kingsbury, M. D., and Boas. The purpose of this and other drives for funds has been to raise money primarily for the use of the Communist Party. Testimony has been presented before the House Un-American Activities Committee that funds collected in drives of this sort have not been used for the avowed purposes stated at the time of collection.

6. JEFFERSON SCHOOL OF SOCIAL SCIENCE (292 AND 293)

The Communist Party has followed the practice of changing the names of individual organizations and fronts when such names have outlived their usefulness. Since it was felt that the Workers Schools throughout the country were too narrowly Communist in their appeal, similar schools have been established ostensibly independent of the Communist Party and under some high-sounding title to attract a wider circle into the Communist web. The first school of this kind was the School for Democracy in New York City, now merged in the Jefferson School of Social Science, founded by a group of teachers expelled from the public schools of that city because of charges of Communist activity established by the Rapp-Coudert Legislative Committee. The Abraham Lincoln School followed in many respects the pattern set by the School for Democracy.

The circumstances of the opening of the Jefferson School make it clear beyond any shadow of doubt that it is a Communist institution modeled upon the lines of the new Communist policy which led to the decisions to change the Communist Party into some kind of educational association. Most significant of these circumstances is the fact that the Jefferson School of Social Science is the result of a merger of two other educational institutions which were indisputably under the control of the Communist Party, namely, the Workers School and the School for Democracy. For many years the Workers School was the official Communist Party in New York City and the School for Democracy, while pretending to be independent of the Communist Party, was supported by well-known Communists and Communist fellow travelers.

The organizing committee of the Jefferson School, as announced in the Daily Worker, consists, among others, of Walter Rautenstrauch and Max Yergan. The director of the Jefferson School is Howard Selsam, who was dismissed from his teaching position in a tax-supported school in New York on the ground that he was a member of the Communist Party. Selsam's membership in the party was, of course, secret. His party name was "Hill."

Thirteen of the instructors in Selsam's School for Democracy are also affiliated with the National Federation for Constitutional Liberties, and these 13 persons represent a 17 percent interlocking directorate between the two groups. On the school's faculty appear: Michael Quill, Walter Rautenstrauch, Bernard J. Stern, Vito Marcantonio, Max Yergan, and others, including Boas, who is also a member of the NCPAC (927).

7. NATIONAL FEDERATION FOR CONSTITUTIONAL LIBERTIES

NCPAC members who are affiliated with this organization include Louis Adamic, Boas, James A. Dombrowski, Langston Hughes, Max Lerner, Paul Robeson, Raymond Walsh, etc. It is significant that almost 25 percent of this federation are members of the late Sidney Hillman's NCPAC. This federation called a National Action Conference for Civil Rights on April 18–20, 1940, in Washington, and among other things stated:

"In Congress, now ready for enactment are bills on wire tapping; universal fingerprinting; repeal and drastic amendment of the National Labor Relations Act; outlawing closed shops; prohibiting strikes; deportation or concentration camps for aliens; outlawing minority parties; life imprisonment for 'treachery', death sentence for 'sabotage', and life imprisonment for advocating changes in Government. * * *

"Therefore, the National Federation for Constitutional Liberties is calling a National Action Conference on Civil Rights. This is a conference, not for talk, but to plan and act.

"The masses of the people demand, 'No blackout of civil rights!' " (1230).

Among the sponsors of this Conference were: Thomas Addis, M. D., Ernst P. Boas, Prof. Franz Boas, Rockwell Kent, and Prof. William Rautenstrauch.

8. VETERANS OF THE ABRAHAM LINCOLN BRIGADE (270; 498; 564; 580; 715; 750 FF.; 1057; 1165; 1268; 1486; 1538; 1610 FF.; 1647)

The Abraham Lincoln Brigade was the 15th Brigade of the so-called international brigades established by the Spanish Loyalist government in its decree of September 23, 1937. Earl Browder boasted with considerable pride that "over 60 percent of the Lincoln battalion members were members of the Communist Party" (270). The House Un-American Activities Committee has given a list of the high-ranking officers of the brigade who were leading Communists. Among these was Robert Minor, Acting General Secretary of the Communist Party,

U. S. A., who was in charge of the American Contingent of the International Brigade. John Gates, political commissar and lieutenant colonel of the Abraham Lincoln Brigade, was previously secretary of the New York State Young Communist League and a member of the New York State Committee of the Communist Party, U. S. A. William Lawrence, political commissar of the military base at Albacete, Spain, was previously organization secretary of the Communist Party of New York City. Saul Wellman, political commissar of the Abraham Lincoln Brigade, was a member of the New York State Committee of the Young Communist League.

The command of the International Brigade was entirely in the hands of emigres brought in from Russia, including General Emil Klaber (real name Stern), etc. (See further p. 271.)

Recruiting for the Abraham Lincoln Brigade in the United States was in the hands of the functionaries of the Communist Party and was carried on in violation of the laws of this country. The records of the FBI contain considerable data regarding passport frauds in connection with the recruiting.

Senator DONNELL. Doctor, before you proceed, I should like to ask Mr. Sneed of the staff of the committee whether or not there is in the possession of the subcommittee a document which originated from the Committee for the Nation's Health, entitled "Statement on Brookings Institution Report—The Issue of Compulsory Health Insurance," which statement is dated May 13, 1948, and which apparently was a statement of what the statement had been, because it says, "This statement was prepared on behalf of the Committee for the Nation's Health by Channing Frothingham, M. D., of Boston, Michael M. Davis, Ph. D., of New York, Ernst P. Boas, M. D., of New York, and Morris Llewellyn Cooke, of Washington, distinguished consulting engineer."

Mr. Sneed, is this document in the possession of the subcommittee at this time?

Mr. MELVIN W. SNEED (committee consultant). This document was received by the subcommittee, at the request of Mr. Rodgers.

Senator DONNELL. That is, the clerk of the committee?

Mr. SNEED. That is correct.

Senator DONNELL. When was it received, as nearly as you can tell?

Mr. SNEED. May 20.

Senator DONNELL. May 20, 1948?

Mr. SNEED. Yes, sir.

Senator DONNELL. Very well. I will ask that this document be identified as exhibit A, May 27, 1948, and that it be placed in the record.

(The statement referred to follows:)

STATEMENT ON BROOKINGS INSTITUTION REPORT

THE ISSUE OF COMPULSORY HEALTH INSURANCE

Those who asked the Brookings Institution to make this report must have known in advance the conclusions which would be reached, for Dr. Lewis Meriam, who was put in charge of the study, had published 2 years ago a full-length book opposing the entire system of social security and favoring a return to poor relief as the way of taking care of aged, sick, and unemployed people.

This point of view pervades the entire Brookings report. Thus the report says that some individuals and families are not able to pay for adequate medical care and that these people must be given care through public funds or philanthropy. But estimates of the American Medical Association show that not just some of the American people, but fully two-thirds of them are unable to pay for adequate care. Unpredictable sickness costs can hit any family to a degree that only the wealthy can afford, and the fear of these costs makes many postpone or go without needed care. The remedy is not charity. Most Americans will not accept charity. The remedy is health insurance, by which people of all income groups, except the few wholly indigent, can prepay their medical costs and receive care when they are sick as a right and not a charity.

The Brookings report is flatly contradicted by the conclusions reached by the National Health Assembly last week. There, a great gathering of representatives of the medical profession and the public agreed that health insurance should be the basic principle for "financing medical care for the large majority of the American people." The Brookings report has been in print for some time. If its sponsors had had the courage to make it public in advance of the National Health Assembly, its conclusions would have been blasted effectively by that body.

The Brookings report charges that national health insurance would not work because of a shortage of doctors. The AMA, however, has declared that there is no over-all shortage of doctors, although it admits there is a problem of redistributing doctors so that rural areas will get their fair share. National health insurance would provide purchasing power for these areas, and thus would draw doctors into these districts that cannot now support enough physicians. No national health insurance bill would guarantee more service at the outset than can be delivered by existing doctors and hospitals.

The report declares that the selective-service statistics do not measure the Nation's need for medical care. Of course no scientific person considers those statistics to be an accurate measure of anything. On the other hand, the fact that a large number of our young men were found to have diseases and defects that could have been benefited, cured, or prevented, shows that many people who need medical care do not get it. For example, in the single year, 1945, more than 250,000 young men were rejected from Army service because of hernia, a condition easily curable by surgery.

National health insurance is attacked by the Brookings report on the ground that it would involve Government interference with doctors and patients, high administrative costs and a huge Federal bureaucracy. The truth is that the National Health Insurance bill now before Congress gives the prime administrative responsibility to the people and the doctors of each locality and that relatively few Federal employees would be necessary; that all the administrative difficulties which the Brookings report lays at the door of compulsory health insurance plans are also faced and must be solved by voluntary plans. This essential fact is not recognized in the report. At the National Health Assembly, representatives of 14 national organizations, including millions of persons, agreed that voluntary insurance plans are desirable and should continue under a national health insurance plan, but that voluntary plans cannot be expected to cover more than a fraction of the population that needs health insurance.

We deplore a report that is bias parading as science, trying to turn the clock back from social security to poor relief, miscalling the nation's health needs and misrepresenting the national health insurance legislation now before Congress. We deplore the reactionary position taken by the staff of the Brookings Institution in this report, which is far from the progressive outlook of this organization during its early days.

This statement was prepared on behalf of the Committee for the Nation's Health by Channing Frothingham, M. D. of Boston, Michael M. Davis, Ph. D. of New York, Ernest P. Boas, M. D. of New York and Morris Llewellyn Cooke of Washington, distinguished consulting engineer.

May 13, 1948.

Senator DONNELL. I will also ask you to state, Mr. Sneed, whether or not the Christian Science Monitor of March 15, 1948, containing an editorial entitled, "Impartial Report" has come into the possession of the subcommittee, also?

Mr. SNEED. That is correct.

Senator DONNELL. I offer for the record at this time this editorial entitled, "Impartial Report." When did this editorial come into the possession of the subcommittee?

Mr. SNEED. Some time ago. We received it through the mail.

Senator DONNELL. This was prior to the issuance of the final report by the Brookings Institution?

Mr. SNEED. That is correct. That followed the issuance by the committee of the Committee Print on the conclusions of the Brookings Institution's study.

Senator DONNELL. This editorial is now ordered placed in the record in full.

(The editorial referred to follows:)

IMPARTIAL REPORT

Recommendations against the adoption of a national system of compulsory health insurance made by the Brookings Institution of Washington mark a milestone. Most of the discussion to date has originated from partisans on both sides. Many of the claims made for the plan have been extreme.

Meanwhile, the facts about the actual operation of a national program of Government insurance of medical care and cash payments to the sick, financed by pay-roll taxes covering employer and employee and also subsidized by Government appropriation, have been largely overlooked. Now at last Congress is given the conclusions of an institution which for years has been distinguished for its impartial studies of government.

The Brookings inquiry, made at the request of Senator H. Alexander Smith, chairman of a Senate committee holding hearings on health insurance, strongly advises against the Federal Government undertaking socialization in the field of care for the sick.

The investigators reported that this would not bring good results and was not necessary. They warned against the danger of impairment of the quality of medical care, and said that its cost would be increased. They pointed out the improbability that politics could be eliminated from medical service. They noted that good health was not exclusively a matter of medical care. The large majority of American families, they added, are able to pay for medical attention.

These findings by a research organization of the standing of the Brookings Institution furnish one of the most important contributions that have been made to the debate on national health insurance.

Senator DONNELL. Will you state also, Mr. Sneed, whether or not you have procured and there are now in the possession of the subcommittee the following, which purport to be copies of various letters:

1. Document entitled, "Copy," dated September 22, 1947, to Dr. Harold G. Moulton, Brookings Institution, 722 Jackson Place NW., Washington, D. C., with typed words as follows: "(Signed) Morris L.Cooke";

2. Document entitled, "Copy," dated September 22. 1947, addressed to Hon. Robert P. Bass, chairman of the board of Brookings Institution, Peterborough, N. H. at the bottom of which appears in type following the conclusion of the letter the name "Morris L. Cooke" and the symbol of dictation, "MLC:s";

3. Document entitled, "Copy," dated September 26, 1947, addressed to Mr. Robert Perkins Bass, Orchard Hill Farm, Peterborough, N. H., on which following the body of the letter are the words "Yours very truly," and the name "Harold G. Moulton," likewise in type, the dictation mark, "HGM:W Copies to all members of the board of trustees and to Mr. Cooke".

Will you state, please, whether or not these documents I have just detailed, beginning with the one from Mr. Cooke to Dr. Moulton, are in the possession of the subcommittee, and, if so, how they happened to come into that possession, and whether you have seen the originals?

Mr. SNEED. The original documents are in the possession of the Brookings Institution, from which these copies were made. I have personally seen the original documents.

Senator DONNELL. And these copies are now in the possession of the subcommittee?

Mr. SNEED. They are in the possession of the subcommittee, furnished by Dr. Moulton, president of the Brookings Institution.

Senator DONNELL. To the best of your knowledge and belief, each of these documents is a correct copy of the original?

Mr. SNEED. That is correct.

Senator DONNELL. These various documents I have detailed, beginning with the one from Mr. Cooke to Dr. Moulton, are offered and will be incorporated in full in the record. All right, doctor, if you will proceed, please.

(The documents referred to are as follows:)

THE HAY-ADAMS HOUSE,
Washington 5, D. C., September 22, 1947.

DR. HAROLD G. MOULTON,
Brookings Institution,
Washington, D. C.

MY DEAR DR. MOULTON: The enclosed copy of a letter sent today to Hon. Robert P. Bass, chairman of the board of Brookings Institution, I believe has an interest for other members of the board as well.

Yours very sincerely,

MORRIS L. COOKE.

SEPTEMBER 22, 1947.

Hon. ROBERT P. BASS,
Chairman of the Board of Brookings Institution,
Peterborough, N. H.

MY DEAR MR. BASS: For 20 years I have had special opportunities to study medical practice in this country and abroad and to form an opinion as to how satisfactorily current medical service is reaching the needs of our people. During its 5 years of life I served on Ray Lyman Wilbur's Committee on the Cost of Medical Care. For some years I have been a member of the Committee on Medical Economics and I am now a member of the executive committee of the Committee for the Nation's Health, which is advocating the passage of the Wagner-Murray-Dingell bill to provide a system of health insurance as contrasted with relief. This experience has left me with a deep sense of our responsibility to make a high grade of medical care broadly available to all our people. It seems so important to our continued well-being that the admitted difficulties in formulating and executing a comprehensive plan, recognizing the claims of all parties at interest, must be met with all the fortitude and well-balanced technical skill which the National can muster.

On hearing that Brookings Institution was planning an investigation in this field—possibly at the suggestion of Senator H. Alexander Smith's Committee—I called on Dr. Harold G. Moulton, president of the institution, to express the hope that he would so plan the inquiry as to give the community the benefit of as dispassionate judgements as possible. I was informed that it had already been decided that the work would be conducted by Dr. Lewis E. Meriam assisted by Dr. George W. Bachman. At the moment only two limited studies had been planned—one on draft rejectees—but Dr. Moulton said that a broader survey might be started by this fall.

Dr. Meriam as the author of a 1946 Brookings Institution report, Relief and Social Security, necessarily begins with a strong and well-defined prejudice against insurance as contrasted with relief. For in Relief and Social Security Dr. Meriam discards our whole present-day social insurance system with the exception of workmen's compensation which he does not mention. In its stead he proposes a relief system, providing for all major hazards but granting benefits only to needy persons and providing only enough to bring them up to a standard whose minimum is determined by the National Government. The States would be free to add to this minimum.

Dr. Meriam regards social security (1) as merely remedial and defensive and (2) as too costly for our economy to bear. His first point is challenged by an impressive group of authorities, who consider experience in this and other countries to show that social security makes direct and important contributions to the morale of the population and to the efficiency of production. His second point is attacked by experts who regard his cost estimates of social security as too high and his estimates of relief costs as too low.

In application to health service, the relief principle is especially obnoxious, if applied to any group of the population except those who are already receiving subsistence from public authorities. The amount of service provided for a person must be related to his medical needs and cannot be proportioned to his economic status as can cash payments. The unpredictable incidence of illness and its costs supplies an unanswerable argument for distributing these costs among large groups of people and over a period of time and for utilizing, in so doing, the 3 to 5 percent of current income which most American families are now spending for medical and hospital services.

The issue in health service, as I see it, is not between the use of general revenues (taxation) versus the "insurance principle," but concerns the relative place of each. Dr. Meriam's uncompromising attack on the whole social insurance principle certainly threatens a judicial approach to any study made by Brookings in the health field. At least, if such a study is undertaken, the staff making it and its steering or advisory committee should be such as to remove even a suspicion of prejudice or predetermination.

Dr. Bachman has splendid professional standing. But his career has been almost wholly in parasitology with some associated experience in administration. This is hardly the equipment for quickly made studies and authoritative conclusions in a field which has been plowed over by a wide variety of technicians at home and abroad through many years.

In our talk Dr. Moulton referred with approval to certain basic assumptions (to be found on pp. 30–32 of Relief and Social Security—see copy attached), with the remark that if these were accepted, relief and not insurance would necessarily be indicated. If this rather sophomoric and/or naive statement is to stand as a master guide and control, why spend money on an investigation?

I must not lengthen this letter but I think it pertinent to remark that another recent publicaition of Brookings (A National Labor Policy by Metz and Jacobstein) has seemed to merit the type of review which weakens prestige. Those who in my opinion are fully competent to judge hold that this book was written to confirm opinions already held, rather than to state facts judicially.

For instance, William M. Leiserson, formerly Chairman of the Railway Mediation Board and later on the NLRB, and for over 30 years a generally recognized authority in this field, says:

"Metz's main difficulty seems to be his lack of sympathy for some of the more recent legislation. This crops out in almost all the chapters of his manuscript. There is no reason why he should approve or sympathize with all the legislation, or any of it, for that matter. But the reader has a right to expect that description and analysis of laws and administrative policies will be presented as objectively as possible, so he will be in a position to judge of the validity of the author's criticism or disapproval. I think the manuscript fails in this respect to a large extent. * * * My impression was that the laws and decisions were merely being characterized and then the criticisms or judgments were based on the characterizations."

I knew Mr. Brookings and something of the ideals he held. It would in my opinion be far from his thought to arrive at conclusions first and then seek to justify them by a one-sided presentation of the facts. I realize that board members have no right to interfere with what is published but you do have the authority to "approve the principal fields of investigation" and to satisfy yourself "with reference to the intellectual competence and scientific integrity of the staff." I am sending a copy of this letter to each of your colleagues on the Board.

Yours very sincerely,

MORRIS L. COOKE.

A SUMMARY OF THE PUBLICATION RELIEF AND SOCIAL SECURITY, LEWIS MERIAM, THE BROOKINGS INSTITUTION, OCTOBER, 1946, PP. 30–32

"When the time came to arrive at broad conclusions, it was clear that they could be drawn only if assumptions were made with respect to the form of government and the economic system under which the system was to operate and the objectives which were to be sought in establishing it * * *."

"BASIC ASSUMPTIONS

"1. The American form of government is to be preserved. The features of this government which are of major concern in considering the present problem are:

"a. The individual is endowed with certain inalienable rights which are not to be taken from him by the States. They are guaranteed to him by the Constitution. If Congress, the President, or any administrative officer or agency attempts to deprive him of them the action is illegal. So long as the Nation has a government of law and not of men, the courts will protect the individual against any infringement of these rights.

"b. The Government is responsible to the people, who express their will through free and uncontrolled elections. If popular control is to be exercised intelligently, the people must be supplied with adequate, unbiased, factual information regarding the policies and activities of Government. The Government must not control or seek to control public opinion by withholding information or by issuing misleading or inadequate statements. If elections are to be really free, the Government must refrain from passing class legislation, giving special privileges at public expense to minority groups, which may hold the balance of power in the democratic elective process.

"c. Power is constitutionally divided in an effort to prevent any Government, any branch of Government, or any special group in the body politic from acquiring so much that it may exercise that power in the interests of a particular group and against the interests of the general public or of individuals seeking to use or enjoy their inalienable rights.

"2. The American system of free enterprise is to be preserved. Under this system the functions of the Government are to render such public services as are essential, to establish and enforce rules of fair competition in fields where competition is practicable, to prevent the development of monopolies, and in naturally monopolistic fields to regulate and control the monopolistic power in the general public interest. The preservation of this system requires that the Government itself shall not compete with private enterprise in fields where competition is practicable and that it shall not use its power to tax or its power to pledge the public credit further than is necessary to render the essential public services. To the maximum possible extent, it will leave the people free to use the fruits of their labors as seems best to them in their pursuit of happiness.

"3. The social security of the American people rests basically upon the capacity to produce and distribute needed goods and services. Social security systems are defensive devices of secondary importance as compared with constructive measures to increase the productive capacity of the Nation.

"4. For normal people with a sense of responsibility for themselves, their dependents, and their neighbors, productive labor is essential to the pursuit of happiness. Existence on a social security benefit provided in part at public expense cannot bring to normal people the same satisfaction that comes from active participation in productive labor * * *."

THE BROOKINGS INSTITUTION,
Washington, D. C., September 26, 1947.

MR. ROBERT PERKINS BASS,
Orchard Hill Farm,
Peterborough, N. H.

DEAR MR. BASS: In common with other members of the board of trustees, I received a copy of the communication addressed to you by Morris L. Cooke. I have a number of comments to make with respect to this letter.

(1) Mr. Cooke, who is an engineer with whom I have long been acquainted, came to see me early in the summer to express his concern over the rumor that Brookings had been asked by a Senate committee to make some study of the health insurance program. After a few minutes, I said to him, with a smile, that "I assume that the purpose of your visit is to tell me that the vice president of the Brookings Institution lacks competency for such a task." He at once denied that he had any such purpose, and said he only wanted to make sure that we become acquainted with certain points of view with respect to this problem. I told him that as a matter of course we always read all the literature pertaining to the subject and discussed the problem with anyone who thought

he had something to contribute. I said we would be glad to arrange a conference with any group with whom he thought we should discuss the problem. He seemed pleased with this assurance.

Mr. Cooke stated at this meeting that he regarded Meriam's book on scial security as a very bad book. However, when I asked him if he had read it, he had to admit that he had not.

(2) A fortnight later Dr. Meriam and Dr. Bachman had a long conference with Mr. Cooke and a Dr. Michael M. Davis who has long been a protagonist of health insurance. Although in his letter to you Mr. Cooke tried to establish himself as something of an authority in this field, he admitted at this conference that he did not pretend to any expert knowledge, hence he wished Dr. Davis to do the talking with respect to technical matters.

Dr. Davis wished to know what conclusions Meriam and Bachman had. They informed him that they naturally did not have any conclusions in advance—that they would first analyze the data, reserving the conclusions until later. Dr. Davis insisted that it was a naive conception—that one must know in advance what he wanted to show or he couldn't very well write a report. He insisted on this point again and again, and couldn't understand how anybody could take the position that it was necessary to study the data before knowing where he stood. (The truth of the matter is that, after studying this problem all summer, Meriam and Bachman have not yet arrived at any definite conclusions.)

In the light of this conference, it is particularly interesting that Mr. Cooke should now be emphasizing that the trouble with Meriam is that he knows in advance where he will come out.

(3) Mr. Cooke refers caustically to Meriam's book on "Relief and Social Security." This book, which represents 5 years of intensive study of the relief and security problem both in the United States and other countries, is a great contribution. Its general usefulness is suggested by the fact that some thirty universities and colleges are using it as a basic text. We of course knew in advance that it would be attacked by those who are 100 percent committed to a certain program. Dr. Meriam has, however, laid bare the fundamental questions and presented an analysis which necessitates fundamental re-thinking in this whole field. He pointed out with great care that one's ultimate conclusions necessarily depended upon certain underlying assumptions with respect to Government in relation to the life of the people. He then stated a number of assumptions which, in our judgment, reflect the basic conceptions of the American people. If one adheres to these assumptions, his ultimate conclusions will, of course, be essentially different than they would be if he rejects these assumptions or conceptions. The trouble with most people is that they do not think with sufficient sharpness on such issues. (Incidentally, the list of assumptions which Mr. Cooke includes in his letter to you is not the one to which I referred in my conversation with him.)

(4) Our work for the Senate committee does not involve technical questions in the field of medicine or surgery. It is primarily statistical and administrative, though it involves some understanding of public health problems. The experience of both Dr. Meriam and Dr. Bachman, as you know, has given them exceptional qualifications for this work.

(5) Mr. Cooke's sideswipe at the Metz-Jacobstein book requires but a word of comment. In the preparation of these labor studies, conferences were held with Dr. Leiserson with respect to both the factual material and the interpretation. Many of his criticisms and suggestions were incorporated. Some were rejected as evidencing a bias on Leiserson's part or at least a defensive attitude with respect to administrative practices in which he had been a participant. Leiserson accuses Metz of a "lack of sympathy" which is only a way of admitting his objectivity.

Yours very truly,

Harold G. Moulton.

Dr. Shearon. While we are introducing documents, I would like to introduce this one, which I mentioned the other day in connection with the editorial in the Journal of the A. M. A. for May 8. I stated at that time that the opinions expressed in that editorial were not fully representative of opinions of all the doctors of the country, and I wish to introduce here a resolution on the National Health Assembly which was passed on May 15, 1948, which states:

RESOLUTION ON NATIONAL HEALTH ASSEMBLY

Whereas the National Health Assembly on May 1–4, 1948, evolved certain conclusions of the planning committee section 8, medical care, and

Whereas these ambiguous conclusions when analyzed critically, permit of implications which are insidious and sinister and which may be diametrically opposed to those principles espoused previously by the leaders of our profession, and

Whereas the last editorial of the Journal of the American Medical Association, May 8, 1948, apparently palliates the above-mentioned dangers to the American medical profession: Be it therefore

Resolved, That all recommendations of the planning committee be forwarded to the officers and delegates of the American Medical Association so that they may be thoroughly familiar with and informed on these proposals and furthermore it is the judgment of this body that the afore-mentioned editorial should not be the basis upon which they reach conclusions or base action until Mr. Oscar Ewing releases his final report.

The above resolution was adopted unanimously by the House of Delegates of the Association of American Physicians and Surgeons at their meeting, May 15, 1948, Palmer House, Chicago, Ill.

JOSEPH C. BUNTEN, M. D.,
Speaker, AAPS House of Delegates.

Attest:
FREDERICK B. EXNER, M. D., *Secretary.*

MAY 15, 1948.

Senator DONNELL. I desire to offer, and do offer into the record also as bearing on the publicity given to the release of the Committee for the Nation's Health with respect to the Brookings Institution, a clipping from the New York Times on May 17, 1948, which is entitled "4 Doctors Assail Brookings Report."

(The clipping referred to follows:)

4 DOCTORS ASSAIL BROOKINGS REPORT—HEALTH COMMITTEE MEMBERS DENY PHYSICIAN SHORTAGE AND CALL STUDY "BIAS"

Four authorities on medical economics, members of the Committee for the Nation's Health, assailed yesterday the recent study of the Brookings Institution that said the United States did not have enough physicians to meet all demands likely to be made under a Federal program of compulsory health insurance.

Dr. Channing Frothingham of Boston, Michael Davis, and Dr. Ernest Boas of New York, and Morris Llewellyn Cooke of Washington charged that the study was "bias parading as science, trying to turn the clock back from social security to poor relief, miscalling the Nation's health needs, and misrepresenting the national health insurance legislation now before Congress."

Their charge was made in a statement sent to the members of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare, the same group for which the Brookings survey was conducted. The statement said:

"We deplore the reactionary position taken by the staff of the Brookings Institution which is far from the progressive outlook of the organization during its early days.

"National health insurance is attacked by the Brookings report on the ground that it would involve governmental interference with doctors and patients, high administrative costs, and a huge Federal bureaucracy. The truth is that the national health insurance bill now before Congress gives the prime administrative responsibility to the people and the doctors of each locality, and that relatively few Federal employees would be necessary."

The statement also asserted that the Brookings Institution had found that national health insurance would not work because of a shortage of doctors while "the American Medical Association has declared that there is no over-all shortage of doctors, although there is a problem of redistributing of doctors so that rural areas will get their fair share."

"Those who asked the Brookings Institution to make its report," the statement said, "must have known in advance the conclusions which would be reached. For Dr. Lewis Meriam, who was put in charge of the study, had published a full-length book opposing the entire system of social security and favoring a return to poor relief as the way of taking care of aged, sick, and unemployed people."

Dr. SHEARON. In connection with this clipping, I believe it will be found that this was not generally released to the press. It did not appear, for instance, in the Washington papers. It was given to the New York Times, I am almost certain, and did not even appear in all of the editions. It does not say it is AP.

Senator DONNELL. It is my information, although I have no personal knowledge of this, that the substance of this clipping appeared in another New York paper. I do not at all question the correctness of Dr. Shearon's statement. I have no knowledge about it.

Dr. SHEARON. It appeared in New York papers, but did not go out to the Associated Press.

Senator DONNELL. The subcommittee will be in recess until 11 o'clock tomorrow morning.

(Thereupon, at 12:20 p. m., the subcommittee adjourned until 11 a. m., Friday, May 28, 1948.)

NATIONAL HEALTH PROGRAM

FRIDAY, MAY 28, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 1:04 p. m., in the committee room, Capitol Building, Senator Forrest C. Donnell presiding.

Present: Senator Donnell (presiding).

Senator **Donnell**. Let the record show that I have been engaged in another committee meeting and did not arrive until approximately 1 p. m., at the meeting of this subcommittee of the Committee on Labor and Public Welfare.

In view of the lateness of the hour and the pressure of other matters, it is hereby determined that this hearing shall be and is recessed until 10:30 in the morning of Tuesday, June 1, 1948, to convene again in this room.

(Whereupon, at 1:05 p. m., the subcommittee adjourned until 10:30 a. m., Tuesday, June 1, 1948.)

NATIONAL HEALTH PROGRAM

TUESDAY, JUNE 1, 1948

United States Senate,
Committee on Labor and Public Welfare,
Subcommittee on Health,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:35 a. m., in the committee room, Capitol Building, Senator Forrest C. Donnell presiding.

Present: Senator Donnell (presiding).

Senator Donnell. The committee will be in session, please. Dr. Shearon, we will resume with your testimony.

STATEMENT OF MARJORIE SHEARON, PH. D.—Resumed

Dr. Shearon. I am trying now, Senator, to bring together the odds and ends. There are a number of things that have come up that bear directly on the matters that we are discussing, and there are other things that we have said would be put in later, and I want to try to get them all into the record.

The other day you asked me about a Mr. G. W. Grange who was on the staff of the advisory council of the Senate Finance Committee. He was connected with the Metropolitan Life Insurance Co., and you asked me what his previous views had been.

Senator Donnell. I remember that.

Dr. Shearon. I have since learned that he was formerly with the Social Security Board also, so the tie-in there, as I said, was very, very strong, with the whole staff being either presently or in the recent past with the Social Security Board and in the main working for the expansion of the program, so that one might expect that type of report that has come out and is coming out.

I have a few more things about the Physicians Forum. There is a paper named "Counterattack." It is published at 55 West Forty-second Street, New York. The date of this particular issue is May 28, and it is put out by an organization by the name of American Business Associates, Inc.

The members of that organization are former FBI employees and they conduct confidential investigations into subversive activities for business organizations, and in addition to that they put out this weekly letter called "Counterattack." I wish to read into the record a brief statement on page 2 of the May 28, 1948, letter.

> Communists try to take over a medical society. Remarkable proof of Communist strength was given this week in election of officers of Medical Society of the County of New York. This is one of five counties that make up New York City. It's identical with Manhattan Borough.

A Communist front, the Physicians Forum, has long been active in various parts of United States. This year it was strong enough to enter its own slate in race for officers of the medical society. What it counted on was the fact that few of the members ordinarily vote.

The Communists would have won if the old-line group in the society hadn't roused out a big vote by accusing the Physicians Forum of wanting socialized medicine. Actually the question at issue was much bigger than that of socialized medicine. The question was whether Communists should get control of medical society of central borough of biggest city in United States. Last year total vote in the election was 285. This year the Communists alone got more than four times that number. Total vote was 3,287. Old-line ticket got 2,083, Communists 1,204.

Although most of the 1,204 doctors who voted for the Communists' ticket aren't Communists themselves, many of them are. The Communists appealed to non-Communists by capitalizing on real grievances, like discriminatory practices in medicine schools and hospitals, and low pay of doctors who care for the medically indigent in hospitals and dispensaries.

One way to defeat Communist influence is by doing something about these grievances. When Communists get 38 percent of a vote among doctors, it's time to wake up.

And I have here the slate that was put up by the Physicians Forum for the officers in the county medical society. I will not read them all, but I should like to have the full slate included in the record. I might say they put up for president-elect Dr. Ernst P. Boas, who is the chairman of the Physicians Forum, and in the top officers are persons who have been for years on the executive committee of the Physicians Forum and who have been the secretary and treasurer of that lobby organization, so that I now should like to insert in the record this complete slate.

Senator DONNELL. It will be placed into the record at this point.

(The paper referred to is as follows:)

VOTE FOR THE INDEPENDENT SLATE

This is the independent slate running for county society offices, on May 24th, at the Academy of Medicine, 2 East 103d Street:

President-elect, Dr. Ernst P. Boas
Vice president-elect, Dr. Theodore Sanders
Secretary, Dr. George D. Cannon
Assistant Secretary, Dr. Leo Mayer
Treasurer, Dr. Bernard C. Meyer
Assistant Treasurer, Dr. Robert W. Laidlaw
Censors, Dr. Byard Williams, Dr. Viola Bernard

Chairman of standing committees:
  Membership, Dr. John A. P. Millet
  Legislation, Dr. Merrill P. Haas
  Public relations, Dr. Constance Friess
  Medical economics, Dr. Sidney Matthew Greenberg
  Public health, Dr. Leonard Goldwater
Delegates: Dr. Lillian De Muth, Dr. Robert V. Sager, Dr. Leonard Goldwater, Dr. Ruth Foster

N. Y. County Chapter of the Physicians Forum, 510 Madison Avenue, New York City.

Senator DONNELL. Doctor, might I interrupt you just a minute?

Dr. SHEARON. Yes, sir.

Senator DONNELL. Do you have at hand a little pamphlet which you showed me the other day issued by the St. Louis Medical Society, giving reference to an address that you are to make in St. Louis?

Dr. SHEARON. Well, I must confess I have it somewhere but I can't lay my hands on it.

Senator DONNELL. I would like the record to contain that excerpt from the St. Louis Medical Society publication. I have forgotten the exact title of the publication, but it will be inserted at this point. Will you furnish it to the reporter, Doctor, at this point?

It is the weekly bulletin of the St. Louis Medical Society, volume XLII, No. 28, March 26, 1948, giving an article with respect to Dr. Shearon, which appears on page 339. I believe that is all of it, is it not, Doctor?

Dr. SHEARON. No.

Senator DONNELL. There is also a paragraph on page 338 together with the heading: "Make a Date Now to Bring Your Friends to the Tuesday Meeting, March 30." Also the paragraph right after that.

Dr. SHEARON. It starts before that on the preceding page.

Senator DONNELL. Oh, yes. There is also the preceding page beginning with "X" and running through "Y" as indicated here in pencil. The reporter will kindly copy those excerpts into the record.

(The excerpts referred to are as follows:)

THE PROGRAM, TUESDAY, MARCH 30, 1948, 8:30 P. M.

Open meeting of the St. Louis Medical Society, 2839 Lindell Boulevard.

* * * * * * *

"Compulsory Health Insurance and Problems of National Medical Legislation," Marjorie Shearon, Ph. D., legislative consultant, Chevy Chase, Md. (by invitation).

Mrs. Shearon is not only the top-notch authority on national legislative matters concerning medicine and health, but is a dynamic and entertaining speaker who presents her material in an interesting concise manner. She has a greater fund of facts and information about the development of health programs, the Wagner-Murray-Dingell Bill, and the medical legislative program that is to be considered in the forthcoming congressional year. Every physician and every lay person interested in this vital question should hear her message and will have the chance to ask her questions from the floor at the conclusion of her talk. (35 minutes.)

BRING YOUR FAMILY AND FRIENDS

Make a date now to bring your friends to the Tuesday meeting, March 30.

In line with the above editorial we want to urge all of the members of the St. Louis Medical Society to bring their lay friends to hear Marjorie Shearon on next Tuesday evening. This unusual and interesting program was arranged by the St. Louis Radiological Society at the request of the program committee, when other plans for this evening did not materialize. This effort is much appreciated and we hope that other specialty groups will make a similar response when called upon.

Mrs. Shearon is a nationally known writer, lecturer, and legislative consultant. She received her Ph. D. degree in science at Columbia University in 1916. For the past 15 years she has been engaged in public administration at local, State, and Federal levels, including 5 years in the Bureau of Research and Statistics of the Social Security Administration and 4 years with the United States Public Health Service. From February 1945 to March 1947, she was research analyst to the majority conference of the Senate. She served as consultant to the Senate Committee on Labor and Public Welfare, later becoming part-time consultant to Senators Robert A. Taft and Forrest C. Donnell.

Mrs. Shearon operates her own business and is not in the pay of any individual or organization. She has no political, business, or professional ties, nor is she a member of any political party. As a legislative consultant she appears in the public interest, expressing her own views but not speaking for any group or special interest.

During 1944 at the request of Surg. Gen. Thomas Parran she prepared "Ten-Year Post-War Program of the Public Health Service," which covered all phases of a national health program.

Dr. SHEARON. Continuing with the Physicians Forum, they put out a monthly bulletin—no, it isn't monthly. I guess it is put out about six times a year, and in January-February, 1948 they included a report. The only reason I am referring to the report—which is not of particular interest to us—is that at the end of the report appear the names Ernst B. Boas, Sidney M. Greenberg—he used to be the treasurer but now he is the acting editor of the organization—and Milton I. Roemer. Roemer is on the staff of the United States Public Health Service and I call attention to the fact that he is signing reports by the lobbying group, the Physicians Forum, which is a Communist front organization.

Senator DONNELL. Is it so termed in the Un-American Activities Committee publication?

Dr. SHEARON. Oh, yes. You will recall that I already read into the record the eight Communist-front organizations that Dr. Boas is concerned with, and, of course, in this citation that I just gave from Counterattack, they just called it Communist. They don't call it Communist front, but plain Communist.

Senator DONNELL. Yes, but I mean in the official publications of the Un-American Activities Committee the Physicians Forum is—am I correct in recalling that it is—declared to be a Communist front organization?

Dr. SHEARON. Yes; it is referred to on page 1627 on these House reports on Communists.

Senator DONNELL. Would you mind checking on that and see what is said there about it?

Dr. SHEARON. Well, the only citation that refers to the organization is one listing Boas as chairman of the organization. It does not speak about the organization as such. I myself have consulted the files in the House and they do have the Forum there with other Communist-front organizations, but they have gathered their material apparently since the publication of this report in 1944.

All that I can say is, then, that while the organization itself is simply listed here indirectly through the Chairman Boas, who is listed eight times as connected with subversive activities, the House itself in this publication does not list it as a subversive organization.

I might say over and over again, as I have given this long account of Boas, his own connections together with the connections of other people in the Physicians Forum all tie in with these groups. For instance, there is Robeson, who has refused to state whether or not he is a Communist.

There is a long line of persons. It is a lot of work to do this, but I would be very glad to give you just a few of these persons with the interlocking connections in addition to Boas who are in the Physicians Forum and give you the connections in a very short space. It takes a lot of work to do it, but I think it is very important.

I think the picture is gradually emerging of these groups on the outside, and they are tying, they are interlocking, with persons inside the Federal Government who are working along with them and aiding in putting over this program.

Senator DONNELL. Well, I was particularly concerned with the Physicians Forum. I understood you to term it to be a Communist-front organization.

Dr. SHEARON. That is right.

Senator DONNELL. And you referred to the eight organizations with which Dr. Boas is connected.

Dr. SHEARON. Yes, I put that in the record just the other day.

Senator DONNELL. I am not certain whether I was quite correct in saying this, whether or not my recollection was correct. Was it your testimony that these organizations were referred to the House Un-American Activities Committee as being subversive organizations or Communist front organizations or something to that effect?

Dr. SHEARON. That is correct.

Senator DONNELL. And the Physicians Forum is among the eight. Is that right?

Dr. SHEARON. No.

Senator DONNELL. It is not?

Dr. SHEARON. No, it is not among the eight listed. There are eight other ones that, shall we say, are much better known for being concerned primarily with Communist activities, whereas the Physicians Forum, shall we say, is primarily concerned with medical legislation.

Senator DONNELL. The Physicians Forum then is not termed a Communist front organization by the House Un-American Activities Committee?

Dr. SHEARON. No. They have material on it with the rest of their file, but they have not printed on it yet. Probably if they were to print a later edition of this same volume, they would include them.

Senator DONNELL. But they have not done so?

Dr. SHEARON. They have not done so as yet. That is perfectly clear. On the other hand, I should just read the opening statement here which I incorporated into the record.

> Boas has been a member of at least eight Communist-front organizations which have been organized by members of the National Citizens Political Action Committee. The same names appear over and over in these committees and include, beside Boas, his late father, Franz Boas, Peter Shipka.

Peter Shipka is one of the top officers of the International Workers Order which is an admitted Communist organization. It includes Rockwell Kent, now the president of that organization, Henry Siegrist, who was for years with Johns Hopkins and has written on red medicine, a thorough believer in the Russian system and who would like to see it instituted in this country. He has worked with Falk and with Boas, and so on. There is also in this list Max Lerner, George Soule, John Peters, M. D., of Yale, and numerous others.

Then I go on to give this list with the citations about their objectives, what they have done and who have been associated with them, name by name right down through the list, but the Physicians Forum is not in that list, although it is now not labeled Communist-front but straight Communist in this Counterattack.

Senator DONNELL. Who gets this paper out?

Dr. SHEARON. American Business Associates, Inc.

Senator DONNELL. Do you know what that organization is?

Dr. SHEARON. Well, I just explained.

Senator DONNELL. I mean who are behind it.

Dr. SHEARON. They are paid, I believe, on a fee-for-service basis for the investigations that they make at the request of business organizations who wish to look into the record of employees or prospective employees about whom they have some doubt.

Senator DONNELL. Do you know who the head persons are in this organization? What do you say it is called?

Dr. SHEARON. American Business Consultants, Inc., and the head man I think is named Mr. Keenan. I could get that information for you and insert it at this point in the record.

Senator DONNELL. Would you do that, please?

Dr. SHEARON. I think that would be rather important.

Senator DONNELL. And if you desire to insert any other information which you said you could get in a small compact unit but which you thought was quite important about these organizations or affiliating, interlocking connections, it will be inserted at this point in the record.

Dr. SHEARON. I have made this point about Milton I. Roemer. He has been speaking around the country in favor of the Wagner-Murray-Dingell bill. I introduced into the record the other day a newspaper clipping about his activities in Washington when he spoke here in Washington about the Murray-Wagner-Dingell bill, straight lobbying activities and no doubt about it because he mentioned the bill by name.

I wish to call attention to the fact that he has published an article which must have taken a considerable amount of time to write, on rural health programs in different nations. It was published in the Milbank Memorial Fund Quarterly, Volume 26, Number 1, January 1948, pages 58 through 89, and among his acknowledgments—and I might say that he is on this staff of Dr. Joseph W. Mountin at the Public Health Service who has also been lobbying for the Wagner-Murray-Dingell bill—and among the acknowledgments he says here:

> For technical assistance in the preparation of this paper, acknowledgment is gratefully made to George St. J. Perrott, Miss Martha D. Ring, Arthur Weissman, and E. B. Kovar.

I wish to call attention to the fact that Martha D. Ring has been associated with Falk for nearly 20 years from the days of the Committee on the Costs of Medical Care. She helped at that time to edit a volume. Her name appears on the flyleaf of the volume as one of the authors, but her work was largely editorial at that time.

She came to the Social Security Board right at the beginning and was on the editorial staff of the Board and was for a number of years responsible to Mr. Falk. In other words, he had the oversight of the editorial publications put out by the Social Security Board.

About 2 years ago she went to the Public Health Service immediately following a trip that was made to Europe by Mr. Perrott and Dr. Mountin to study health insurance schemes in Europe. She went over to Mr. Perrott's staff to do the main writing on that report on European health insurance.

In other words, she can take the material that is brought in, put it together, and write it up. Now she has just been employed by the Finance Committee to work on their reports for the Advisory Council.

Senator DONNELL. Senate Finance Committee?

Dr. SHEARON. Senate Finance Committee. And I wish to point again to the fact that employees who have been responsible for years to these Government officials even before they were Government officials, i. e., the persons who have been working for the nationalization of medicine—that these employees are creeping into one committee after another and are making their presence felt.

Now this organization, the Physicians Forum, which has been working for the Wagner-Murray-Dingell bill, has been given very kind treatment, shall we say, by Mr. Ewing, and when they wanted someone to speak on compulsory insurance they selected Dr. Boas and he gave the main speech at the National Health Assembly.

Senator DONNELL. That is the one held here in Washington?

Dr. SHEARON. It was held here on May 1 to 4, 1948. On May 25—that was last week—this same group was permitted to use Government space for a meeting called a scientific meeting, and probably it was in the main scientific, but I raise a question whether that group should have been allowed to use Government space even if they rented it, in view of the fact of the long-time connections of the head of that organization with Communist fronts, and the purpose of the organization.

Senator DONNELL. Doctor, you have just handed me a paper reading as follows:

> Physicians Forum, D. C. Chapter, Second Annual Scientific Meeting. Dr. Joseph C. Aub, professor of research medicine, Harvard Medical School, will speak on Endocrine Problems in General Practice. Discussion by Dr. Riley F. Thomas, assistant professor of medicine, Howard University. Dr. Roy Hertz, chairman endocrinology section, National Cancer Institute. All physicians are cordially invited. Federal Security Building, Room 5541. (Air-conditioned.) C Street between Third and Fourth Streets, SW., Tuesday, May 25, 1948. 8:30 p. m.

Where did you get that circular? Do you know how it was issued?

Dr. SHEARON. It was sent out by the Physicians Forum to a physician who gave it to me.

Senator DONNELL. The Federal Security Building is a Government building?

Dr. SHEARON. It is a Government building, and I call attention to the fact that there is a very close tie-in and a very friendly reception for persons of that lobbying group.

This Dr. Roemer is a member of the top council. He is a national representative elected to the top council of the Physicians Forum and he also was sent to Japan, I might say. I will come to Japan later.

Now I have a few additional things to say about the Committee for the Nation's Health. I wish to call attention to the fact that the persons who have been providing the funds to support that organization are in the main members of the Rosenwald family which has backed Michael M. Davis for many years, going back into the 1920's even before his association with the Committee on the Costs of Medical Care when he himself was a research director with the Rosenwald fund.

I should like to insert into the record at this time this list of contributors to the Committee for the Nation's Health which came from the records of the clerk in the House who has the reports on lobbyists.

Senator DONNELL. These are contributions of more than $500, January 1, 1947, to March 31, 1947. This list will be incorporated into the record at this point.

(The list referred to is as follows:)

COMMITTEE FOR THE NATION'S HEALTH

Contributors of more than $500, Jan. 1, 1947, to Mar. 31, 1947:

Marshall Field, 250 Park Ave., N. Y.
Mary Lasker, 29 Beckman Place, N. Y.
Mrs. Max Ascoli, 23 Gramercy Pk., N. Y.
Mr. Lessing Rosenwald, Jenkintown, Pa.

April 1, 1947, to June 30, 1947:

Mrs. David Levy, New York City.
Mr. Albert D. Lasker, New York City.
Edith R. Stern, 840 Union St., New Orleans, La.
Bernard Reis & Co., 10 E. 40th St., New York City.
Mrs. Gardner Cowles, 29 E. 69th St., New York City.
Congress of Industrial Organizations.

October 1, 1947, to December 31, 1947:

Mr. William Rosenwald, New York City.
Mr. Gardner Cowles, Register & Tribune Co., Des Moines, Iowa.

Dr. SHEARON. Edith R. Stern, 840 Union St., New Orleans, is listed there. I was a little surprised to find someone so far away from this movement, which is usually a New York City movement. I found out that the explanation is that her husband was formerly on the board of directors of the Rosenwald Fund when Michael M. Davis was there, so it is a matter of personal friendship rather than a desire to support the nationalization of medicine.

The man himself, Mr. Stern, appears to be in favor of the present way of running this country and the free enterprise system, the capitalist system. It is a donation for friendship's sake.

I should like to call attention at this time to a meeting that was held on April 1, 1946, at the Carlton Hotel, and at that time the news was given out to the press that they were forming a new pressure committee to lobby for the Wagner-Murray-Dingell bill.

That, you will recall, was the time when we were having the hearings on S. 1606 and I think it is significant that among the persons who were present at the speakers' table were Arthur J. Altmeyer, a Federal employee, who has stated that if anyone can prove he has spent 1 cent of public funds for the promotion of the Wagner-Murray-Dingell bill, he will resign.

I think this is another case in point because he was paid by the Government on a full-time basis at the time he attended this meeting to form the Committee for the Nation's Health, a lobbying organization.

Also at that table were Watson B. Miller, Representative Dingell, Bertram Myron Gross, who was later employed by the Education and Labor Committee and worked for a long time with the Committee in promoting the Wagner-Murray-Dingell bill. Also at the table was Doctor——

Senator DONNELL. The Labor Committee of the Senate, Dr. Shearon?

Dr. SHEARON. Of the Senate, yes.

Also at that table was Dr. Channing Frothingham. Senator Pepper could not attend but he sent a statement, and also there is Abe Fortas.

There is a great deal to be said about him, but he is now engaged in private law practice here in the District, and you may recall that he was one of those—his name appears on the letterhead of Arnold, Fortas and Porter, law firm—who made a statement at the hearings on S. 545 on July 2, 1947. I won't bother to go into the details of the list of persons who were present at that initial meeting when the organization was started except to say that Mr. James Roosevelt was said to have been present, as well as John Corson and Michael Davis; John Corson was formerly on Altmeyer's staff.

Senator **Donnell**. That is Mr. Corson who is on the Washington Post?

Dr. **Shearon**. He is on the Washington Post. There is listed Michael Davis, Franz Goldman, Kingsley Roberts, and so on, all the list of those that we are very familiar with in this field, and I think it might be helpful to have that list as a part of the record.

Senator **Donnell**. It will be incorporated at this point.

(Dr. Shearon submitted the following paper:)

Committee for the Nation's Health, April 2, 1946

A new pressure committee has been formed to lobby for the W-M-D bills. It met at the Carlton Hotel April 1, 1946. At the speaker's table were:

Arthur J. Altmeyer, Watson B. Miller, Representative Dingell, Mrs. Keyserling (Washington office manager), Bertram Myron Gross, Abe Fortas; Fath, general counsel from Office of War Mobilization and Reconversion; Channing Frothingham, M. D.; Senator Pepper could not attend but sent a statement.

INCOMPLETE LIST OF COMMITTEE MEMBERS

Jonathan Daniels, Russell Davenport, J. O. Davidson, Bishop Francis J. McConnell, Philip Murray, Bishop G. Bromley Oxnam, Mrs. Roosevelt, David Sarnoff, Gerard Swope, John Corson, formerly with Social Security, now with Washington Post, James Roosevelt, Abe Fortas, Raymond Swing, Cecil Brown, James M. Patton, Anna M. Rosenberg, Dr. Miles Atkinson, R. M. Walls, D. D. S., Stuart Chase, Michael Davis, Roger Baldwin, Alice Hamilton, M. D., John P. Peters, M. D., Allan Butler, M. D., Ernest Boas, M. D., John O. McCall, D. D. S., Thomas G. Addis, M. D., Franz Goldman, M. D., Kingsley Roberts, M. D., Mary Dublin Keyserling, (Washington office manager), N. Kobrin, D. D. S., Alfred Walker, D. D. S., Alfred J. Asgis, D. D. S., Bertram M. Bernheim, M. D., C. E. A. Winslow, Dr. P. H., Herbert E. Phillips, Johannes Steel, Anna M. Kross, Matthew Woll.

Address: Committee for Nation's Health, 1790 Broadway, New Yok City 19, New York.

Chairman: Channing Frothingham, M. D., Boston, Mass.

Note: Committee headquarters are at the same address as the Committee on Research in Medical Economics of which Michael M. Davis is chairman, Fred Stein is treasurer, and Paul Kellog is secretary. Dr. Frothingham is a member of this committee, as is Walton Hamilton, professor of law, formerly at Yale, also first director of research and statistics at Social Security Board, and associated with Falk on the Committee on the Costs of Medical Care.

Dr. **Shearon**. I might also say that there is an interlocking membership with the Southern Conference for Human Welfare, which is listed as a subversive organization in the report on Southern Conference for Human Welfare, Report No. 592, Eightieth Congress, first session.

Senator **Donnell**. That is the organization with which Dr. Clark Foreman is connected?

Dr. **Shearon**. That is correct, and there is an interlocking membership there.

Senator **Donnell**. We will be in recess for a few minutes.

(Short recess.)

Senator DONNELL. All right, Dr. Shearon, will you please proceed.

Dr. SHEARON. In winding up my statements about the Committee for the Nation's Health, we would not have the completed picture if I did not refer to Mr. Reidy who was with the Committee for the Nation's Health until he came to the staff of Senator Murray on May 19, 1947, 2 days before the hearings on these two bills started, and since that time he has played a very active role.

In December last year he went off of Senator Murray's pay roll and back to the pay roll of the Committee for the Nation's Health as a lobbyist at $6,500 a year for the purpose of putting through the Wagner-Murray-Dingell bill, and he held that position at the time we resumed hearings in January this year when he was here sitting at the Senator's table and conversing freely with Margaret Stein, the Washington representative of that organization, and with Nelson Cruikshank, who was one of those committed to enactment of the bill.

He remained with the Committee for the Nation's Health until about the middle of March, and has since that time returned to Senator Murray's pay roll. His background and lack of professional training become matters of importance when he assumes the role he does in connection with these bills.

I have a statement here that has come from Government records in regard to his place of birth. He was born in New York City. During the war he obtained a classification that was rather unusual, namely, he was deferred but not placed in an essential job so that he was free to do a large amount of annoying of the Government during the war, and he proceeded to do so out in the western States, in California and other nearby western States, to such an extent that he was investigated by the Bureau of Investigation, and they have been investigating him ever since but have not published a report on him, but they have records on him.

It is significant that he started in a very small job in the Government during the war and then made use of that job to annoy the Government.

When he applied for Federal employment, among the persons that he gave as his references—and you generally would give as a reference the person that you thought highly of and with whom you had been associated and who knew about your work—was Dr. Fred D. Mott, whose name has come up often in connection with his activities in the Department of Agriculture, and, as I said, he is now in Saskatchewan running a Socialist medical program. He also gave the name of Dr. Alexander Meiklejohn who has been associated with Communist-front and Communist organizations which are listed here.

The significance of this is perhaps at least that Mr. Reidy has had his connections with these same subversive groups of which we are speaking, and I should like to introduce this statement into the record.

Senator DONNELL. It will be included in the record at this point.

(Dr. Shearon submitted the following paper:)

MAY 28, 1947.

MEMORANDUM REPORT

Subject: William G. Reidy
Re: Background information

William Gerard Reidy was born in New York City on September 16, 1910, of Irish-American parents. He received his early education in New York public schools. In 1930 he entered the University of Wisconsin, at Madison, graduating in 1934 with a B. S. degree. Pursuing his chosen field of education and economics Reidy earned an M. A. degree in 1936 from the University of California, Berkeley, Calif.

Since 1936 Reidy has claimed California as his legal residence and for many years resided at 1843 Divisadero Street, San Francisco, Calif. He is married and was placed in class 3–A, during the past war, by local board No. 70 in Berkeley.

The records on file in Washington, D. C., show his employment from 1937 to 1943. The first position listed covering the period from August 1937 to June 1939 shows Reidy engaged as an instructor in the social sciences at the Visalia Junior College, Visalia, Calif. In this position he was compensated at a rate of $1,850 per annum.

From October 1939 to February 1943 he was employed as associate educational adviser in the division of planning and research of the California State Relief Administration at an annual salary of $2,200. In this position he interpreted the laws on reemployment to inquiring citizens and was called upon to conduct public speaking tours in connection with the service training program of the California Relief Administration.

From June 1940 to March 1943 he worked for the FSA, USDA, as a specialist in the health service and was compensated for his services at a figure ranging from $2,600 to $2,800 per annum. In this position the work entailed supervision of health services in four States Reidy was responsible for training and supervising the field personnel, handling liaison with related agencies, and planning and conducting research in this particular field.

On his application for Federal employment Reidy gives the following individuals as references:

(1) Dr. Alexander Meiklejohn, Dodge Hotel, Washington, D. C.

(2) Mr. Edward Howden, San Francisco, Calif., secretary of the Housing and Planning Association.

(3) Dr. Fred D. Mott, FSA, USDA, Washington, D. C., chief medical officer.

(4) Mrs. Florence Wyckoff, 3416 Que Street, Washington, D. C., formerly with the California Relief Association.

(5) Dr. Omer Mills, USNHA, FPHA, San Francisco, Calif., regional manager.

The records on file in other Government agencies reveal no derogatory information pertaining to the subject of this report. However, it was noted that two of the references given by Reidy in an application for Federal employment have been affiliated with Communist-front organizations in the past.

Alexander Meiklejohn's name appears on the sponsor list for a dinner held at the Hotel Biltmore, in New York City, on April 17, 1940, which was given under the auspices of the American Committee for Protection of the Foreign Born. He also sponsored the dinner party arranged for the delegates to the fifth national conference of the American Committee for the Protection of the Foreign Born held in Atlantic City on March 29, 1941 (appendix IX, House committee files, pp. 348 and 354). The American Committee for Protection of the Foreign Born was originally known as the National Council for the Protection of the Foreign Born. It was founded by the Communist Party for the purpose of exploiting racial divisions in the United States. Many Communist agents operating in this country have been protected by the committee. In this latter connection the committee has openly cooperated with the International Labor Defense, the legal aid arm of the Communist Party.

The records show that in 1938 Meiklejohn was a member of the advisory board of the American Student Union (appendix IX, House committee files p. 523). The American Student Union was formed in Columbus, Ohio, in December 1935 and resulted from a merger of the National Student League and the Students League for Industrial Democracy the former being Communist dominated and the latter a socialist organization. The American Student Union was under Communist control from the very beginning and on numerous occasions has exposed its connections with the Communist Party.

Omer Mills is shown in the 1940 listings of the Social Work Today as a contributor. Social Work Today is a magazine founded in 1934. A study of its contents show the magazine to be a vehicle of expression for the Communist Party line in the social work field (appendix IX, House committee files, p. 1782).

Remarks.—The connections of the two references given by Reidy are included for what they are worth in judging the subject. They are all old offenses and might well be the result of innocent sponsorship. However, in any event it is well to keep these in mind as Reidy thought enough of the two individuals to mention them as character references.

Dr. SHEARON. Now the other day a letter was read into the record from Senator Murray stating that he wished to have an analysis made of the Brookings report by two organizations. One was the Committee on Research in Medical Economics, that is, the committee which has published this lobbying report which I have referred to frequently, the 1944 report entitled "Principles of a Nation-wide Health Program."

Now that was put out by the Committee on Research in Medical Economics which was the one that Senator Murray wishes to use, and I point to that to indicate that it is not likely to be strictly a research report.

The other organization that was referred to was the Public Affairs Institute. I have looked up a little bit about that institute and I find that Senator Ball on April 2 of this year had a good deal to say about that organization, the members of it and the financing of it, and I refer to the Congressional Record of that date.

Senator DONNELL. Give us the date, please.

Dr. SHEARON. The article starts on page 4153 and 4154. It would hardly be necessary to have the whole article in, but at that time the Public Affairs Institute prepared a minority report in connection with labor and management relations, and Senator Pepper and Senator Murray also filed that minority report.

Senator Ball said that ordinarily there wouldn't be much to be said about the filing of a minority report. It was a customary thing, but that because of the character of the organization that prepared the report, he therefore had these things to say.

I will not bother to read them, but I think it would be helpful to this committee to realize the character of the two organizations that would be preparing the report. Now there is also something further in regard to this organization.

Senator DONNELL. That is the Public Affairs Institute?

Dr. SHEARON. The Public Affairs Institute.

Senator DONNELL. May I see Senator Ball's speech to which you referred, Dr. Shearon, please?

Dr. SHEARON. It begins over on the preceding page there, Senator.

Senator DONNELL. Doctor, I think it would be very well to put this speech of Senator Ball's into this record.

Dr. SHEARON. It would not be too long. It is mostly about this, and he there refers also to a statement which had been put into last year's Congressional Record of July 9, 1947. It is referred to in the first column on 4154.

Senator DONNELL. Well, this speech of Senator Ball's, beginning in the second column of page 4153 and concluding in the second column of page 4154 will be incorporated at this point in full in the record.

(The speech referred to is as follows:)

LABOR-MANAGEMENT RELATIONS—MINORITY VIEWS PRESENTED BY MR. PEPPER

Mr. BALL. Mr. President, on March 15, 1948, the Joint Committee on Labor-Management Relations filed its progress report, as required by the Labor-Management Relations Act.

Last night the Senator from Florida [Mr. Pepper] on behalf of himself, the Senator from Montana [Mr. Murray], and Representatives John Lesinki, of Michigan, and Augustine Kelley, of Pennsylvania, filed minority views in connection with the report of the majority of 10 members of the joint committee. Ordinarily I would not comment on the filing of minority views, but I think the circumstances in connection with the filing of the minority views are so unusual that I cannot let the opportunity pass without placing a few facts in the Record.

The first fact goes to the interest shown by the four members who filed the minority views in the work of the joint committee. Since our organization last summer the committee has held four major meetings. The first one was on October 7 and 8, of 1947, when we had a review of the staff work up to that time. None of the four minority members who filed minority views was present at those meetings.

On December 17 we held another meeting, at which we reviewed the staff work up to that time; and again all four of these members were absent.

On March 1 we held a meeting with the National Labor Relations Board, at which we reviewed the Board's work in connection with the law up to that time. Representative Kelley was present at the meeting for the first time, and the Senator from Montana [Mr. Murray] was present. The other two members who signed the minority views were absent.

On March 9 and 10 the committee met both days to view the preliminary report which was filed on March 15. The Senator from Montana was present on both days for a short time. None of the other three members signing the minority views were present on either day.

Furthermore, Mr. President, neither the chairman of the joint committee—myself—nor the chief counsel, Mr. Thomas E. Shroyer, has at any time received any suggestions from any one of the four minority members who in their minority views, condemned the majority report so vehemently as to the work of the joint committee, its staff, or what should be included in its report. It seems to me rather unusual for minority members of a committee who have shown so little interest in the work of the committee suddenly to develop minority views.

I think the answer is perhaps found in the preface to the minority views, which contains this paragraph:

"We called upon the Public Affairs Institute, a scientific research organization, to assist us in assembling the data which underlie this report. The institute's specialist in labor-relations problems, Herman Lazarus, has rendered the minority untiring expert assistance."

I was rather interested in what the Public Affairs Institute is, and who Herman Lazarus is. It develops that Herman Lazarus was a legal assistant to former general counsel Gerhard Van Arkel, of the National Labor Relations Board, in charge of legislative liaison; and all during the debate last year on the Taft-Hartley bill he sat in the gallery and conferred with Senators who were opposing the passage of that bill. When the chief counsel, Mr. Van Arkel, resigned from the National Labor Relations Board, claiming that the Taft-Hartley Act was unworkable and I may add that he is now counsel for the International Typographical Union—Mr. Lazarus also resigned, and apparently is now the labor relations expert for the Public Affairs Institute, which is labeled as a scientific research organization.

The origin of the Public Affairs Institute, which issued its first report in February 1948 is rather interesting. The head of the sponsoring committee was Mr. A. F. Whitney, president of the Brotherhood of Railroad Trainmen, whose position in regard to labor relations and labor relations legislation can hardly be termed scientific or objective.

The same applies to the other sponsors listed in a letter signed by the executive director of this so-called research institute, who is Dewey Anderson. Senators may recall that in 1946 Dewey Anderson was head of the staff of the Small Business Committee of the Senate, and was under constant fire from Senators because of his slanting of hearings and reports of the committee. He is an extreme political left-winger, and seemingly could not keep from inserting his personal views into reports of the committee.

Representative Thomas L. Owens, of Illinois, inserted in the Congressional Record of this year, at page A3635, a circular issued by the Grand Lodge of the Brotherhood of Railroad Trainmen, which cites some expenditures made by Mr. Whitney to which exception was taken, showing, for example, that Mr. Dewey Anderson was on the pay roll of the Brotherhood of Railroad Trainmen from February 18 to May 31, 1947, along with a number of other so-called research analysts of writers, including, I might add, Charles Kramer, a research writer who drew $2,250 from the Brotherhood of Railroad Trainmen during that year. To those who are familiar with subversive activities and Communist activities in Washington, D. C., the name of Charles Kramer will be very familiar.

> So I submit that this so-called scientific research organization, the Public Affairs Institute, is extremely far from being a research organization, and should be more properly labeled a straight propaganda organization.
>
> I do not care to comment on the body of the minority views. I think they speak for themselves. Any Member who cares to read them will see that they are a straight presentation of extreme left-wing union views. I may add that the only sources quoted in the report are such statements as these: "It is generally recognized by experts," or "It has been widely reported," or such a general statement as "Bootleg contracts have become the fashion." Those are the sources for many generalizations and findings proceeding from that basis. There are no facts to amount to anything in the report, whereas I believe that every single finding in the majority report is supported by a wealth of factual material.
>
> As I say, it is unusual, and I do not like to make such a statement about a minority of the committee of which I happen to be chairman; but I think the circumstances demand that the facts of the situation be placed in the Record.

Dr. SHEARON. And you may possibly feel, in order to get these all together, because it is frequently difficult in chasing back to things earlier in the record—you have the story before you when you consider the credibility of the report and the persons who have prepared it. There is this article that Senator Ball referred to on page A3635 for July 9, 1947.

This is a circular letter that was put out by A. F. Whitney, president of the Brotherhood of Railroad Trainmen. Now Whitney is the man who is back of this Public Affairs Institute.

Senator DONNELL. He is referred to in Senator Ball's speech, I notice.

Dr. SHEARON. That's right, and he was the one who initiated this institute for the railroad brotherhood so it would have a particular purpose. It was not a general research organization like the Brookings Institution, but was set up to serve the brotherhood. This is somewhat longer, but it gives the sources of funds and so on. It is 3½ pages.

Senator DONNELL. Let me see that, Dr. Shearon, please. I see Mr. Whitney refers to this bureau as the Public Affairs Research Institute.

Dr. SHEARON. Sometimes it is called that.

Senator DONNELL. Is that the same as the Public Affairs Institute?

Dr. SHEARON. It is called that part of the time and part of the time Senator Ball referred to it as the Public Affairs Institute and left out the word "Research" but it is the same organization. They have their offices down here at 312 Pennsylvania Avenue SE.

The significant things in that second article are some of the persons who are on the staff, namely Charles Kramer, who was the staff director of the Pepper Subcommittee on Health and Education.

Senator DONNELL. I think it would be well to have the following excerpt from this letter by Mr. Whitney in the record. This appears at page A3636. It says:

> I discusssed with leaders of the brotherhood and of certain other labor organizations the advisability of establishing a research bureau in Washington, D. C., to be headed by a competent economist that would enable the brotherhood, working independently or jointly with other groups, to carry on a comprehensive research work to assist our national legislative staff and me as well as our friends in Congress. Research is an absolute necessity if an effective public-relations program is to be carried out.
>
> Plans for this bureau, to be known as the Public Affairs Research Institute, envisioned that it would be set up as an independent, nonprofit organization financed by donations from a group of founders, including labor organizations and other liberal-minded citizens. Its objectives would be to provide essential

data on matters about which public policy is to be made and to highlight the real policy issues and alternatives involved in the maze of political jockeying, by

(1) Servicing friendly Members of Congress, participating labor unions, progressive, religious, and other groups with basic background memoranda on pending legislation affecting labor;

(2) Sponsoring policy conferences on major issues in Washington and elsewhere between lawmakers, experts, and public citizens, thus providing a "close to the firing line" forum for balanced discussion;

(3) Undertaking basic action research, incorporating the efforts of specialists throughout the country on vital international and domestic problems confronting the Government;

(4) Providing the raw materials for a public information drive through existing media of communications, field organizations, regional conferences, etc., to educate the general public on the real basic issues underlying the problems confronting labor.

This program was laid before the general secretary and treasurer and board of trustees, and I requested authority to spend up to $100,000 from the national legislative revolving fund to promote the program which also included expenses involved in contacting Members of the Congress, and contributions to one or two groups cooperating with us. At the time it was considered by the trustees, Brother B. J. Baumberger was absent. However, Trustees G. J. Giguere and E. C. Bassett approved my request, as did the general secretary and treasurer, and I continued to take steps to implement the plan.

Well, when you get started on this it is hard to find a breaking off place.

Discussions were held with our general counsel, trusteeship papers were drawn up and a trustee tentatively appointed. I conferred with Mr. Philip Murray, president of the CIO, at Pittsburgh, Pa., February 6, 1947, who stated that he approved the program and that he believed that his board of directors would concur.

With President Murray's tentative assurance of cooperation, plans for the institute progressed to the point where it was determined that a budget of $40,000 would be sufficient to meet the expenses of the institute in 1947, and I arranged for the brotherhood to deposit $10,000 in a Washington, D. C., bank to get the institute started.

In the meantime, due to the delay in getting it started, the national legislative representative and I agreed that it would be necessary to employ additional help to fill the immediate need for research and the preparation of materials necessary to offset the terrific pressure for passage of the Taft and Hartley slave labor bills.

Dr. Dewey Anderson, an economist of exceptional ability, honored by the highest rating the United States Government could give, had been chosen by the sponsors of the institute to act as director when it was set up, and on February 17, I employed Dr. Anderson to work for the brotherhood in a similar capacity on a temporary basis at a salary of $1,000 a month, with the understanding that any salary and expense payments made to him would be deducted from the brotherhood's contribution to the institute when it was finally set up. I also authorized him to employ a stenographic assistant.

On February 25, I arrived in Washington with a check for $10,000 in my pocket, prepared to carry forward the arrangements which had been made and which had to that moment been approved.

However, on the morning of that date I received a telegram from Trustee Bassett withdrawing his support of the $100,000 appropriation and later during the day I received a letter from him confirming his telegram. On the following day Trustee Baumberger wrote me in the same vein, advising that he concurred in the action taken by Trustee Bassett.

This left the brotherhood and its president in a very embarrassing position as I was forced to withdraw the brotherhood's offer of support of the research institute after having agreed that it was necessary if our friends in the Congress were to have any help in their efforts to save even a part of the gains made by labor during the Roosevelt administration.

Upon our withdrawal as a sponsor of the research institute the project collapsed. The $10,000 check was returned to the general secretary and treasurer, and I took steps to make such emergency arrangements as appeared to be necessary to tide the situation over and to enable the brotherhood to throw its influence and weight against the vicious bills pending in the Congress.

Now Doctor, I hadn't observed until this moment about this collapse of this project. Are you quite sure that this Public Affairs Research Institute that Mr. Whitney is writing about here is the same one to which Senator Murray referred?

Dr. SHEARON. It has been able to keep alive and have some money because they are a going concern and they put out their first big report in February 1948, Senator Ball states.

Senator DONNELL. You think it is the same organization. Is that right?

Dr. SHEARON. Well, I do not see any reason to question it. Senator Ball states here——

Senator DONNELL. Senator Ball refers to Mr. Whitney in that statement which has been introduced into the record?

Dr. SHEARON. Well, of course it must have been because as a matter of fact Senator, Senator Murray and Senator Pepper have stated here, according to Senator Ball, that they called upon the Public Affairs Institute. That is what it is called here.

Senator DONNELL. It is called that in Senator Ball's statement, is it?

Dr. SHEARON. Yes.

Senator DONNELL. What does it say about Mr. Whitney in there, Doctor?

Dr. SHEARON (reading):

> The origin of the Public Affairs Institute which issued its first report in February, 1948 is rather interesting. The head of the sponsoring committee was Mr. A. F. Whitney, president of the Brotherhood of Railroad Trainmen, whose position in regard to labor relations and labor relations legislation can hardly be termed scientific or objective.

Senator DONNELL. You are quoting now from what?

Dr. SHEARON. From Senator Ball's statement, on page 4154, on April 2nd, 1948.

Senator DONNELL. I notice Mr. Whitney also has this to say. He says, page A3637:

> Our temporary research staff will be continued until adjournment of the present session of Congress. It is, however, only a stopgap to fill our urgent and immediate needs. The proposed research institute would be more comprehensive in coverage on pertinent subject matters and would provide a year-round source of material for the brotherhood in its effort to better the lot of its membership, and in the long run less expensive, as our contribution would cover the entire expense to the brotherhood.

You referred, I think, to Mr. Charles Kramer, did you not?

Dr. SHEARON. Yes.

Senator DONNELL (reading):

> Trustee Bassett also objected to payments made to Mr. Charles Kramer, whom I retained for a 3-month period.

What information do you have about Mr. Kramer?

Dr. SHEARON. Well, you may or may not recall in 1946—he was paid $2,250 here, I see, as research writer, $750 a month for 3 months, it is disclosed. In 1946 he was the staff director of the so-called Pepper Subcommittee on Health and Education of the Committee on Education and Labor. Now he had as his assistant at that time his chief investigator, Leslie A. Falk, so far as I know, no relation to Mr. I. S. Falk. Leslie A. Falk is in the Public Health Service and has been working with the Physicians Forum promoting the Wagner-Murray-

Dingell Bill, so that we have Charles Kramer as the staff director, Leslie A. Falk as the chief investigator, and Charles Bragman, who frequently sits here in the Senate hearings, as a staff member under Kramer.

Now, I know you will recall this instance, indicating perhaps the ethical characteristics of Mr. Kramer and what one might expect. There was put through at that time a rather unusual subcommittee print, an interim report from the Subcommittee on Health and Education to the Committee on Education and Labor, United States Senate. There had been printed by the Pepper subcommittee in March, 1946, a subcommittee report No. 5 on health insurance. This is an interim report from the Subcommittee on Health and Education to the Committee on Education and Labor, United States Senate, pursuant to S. Res. 62—extending Senate Resolution 74, 78th Congress—a resolution authorizing an investigation of the distribution and utilization of health personnel, facilities, and related services. This was printed for the use of the Committee on Education and Labor in 1946, the date being March 1946. Charles Kramer at the time was the staff director, and I know you will recall that very suddenly, in July, 1946, there appeared in the newspapers a publicity release stating that this Health Subcommittee favored health insurance, and the release was put out by Senator Pepper, and the peculiar thing about it was that they had taken this March, 1946, publication on health insurance, which had never been submitted to the subcommittee, as Senator Smith stated on the Senate floor—you were not a member of the subcommittee, but you will recall that Senator Smith pointed out that it had not been referred to the subcommittee, though it came out originally in March, 1946, just before we started the hearings on S. 1606. Then it was reprinted with just a few very minor changes, none of them significant, in July, 1946. That would give the impression that the subcommittee favored compulsory health insurance, and there was a little sticker put on at the bottom of the original report, and this is just exactly the way the sticker was put on [indicating]. It went to the Government Printing Office with this sticker: "Senators Hill, Tunnell, and Morse, because of the pressure of other business, have not completed their study of the subject of this report." However, other members of the subcommittee had not studied it and had not reported on it as it was brought out on the Senate floor, and then you made quite a speech on the subject.

I refer to all of this older history because at that time the man who was managing affairs for the committee was this same Charles Kramer, to whom Senator Ball has taken exception, and who I might say possibly would be the one who would write up the analysis of the report.

Senator DONNELL. You mean he would write it up for the Public Affairs Institute?

Dr. SHEARON. Yes, that is right. And, of course, they might get some help from Leslie Falk, who is now on the staff of the Public Health Service, and who is also very much concerned with getting the Wagner-Murray-Dingell bill enacted into law. And Leslie Falk writes for the Physicians' Forum.

Senator Murray, I think, in that letter made the suggestion that the report that would come out of these two organizations, one a lobbying group and the other the Whitney Brotherhood group—that that report should be printed by the committee and then should have the same circulation that the original report on the Brookings report had had.

I should like to recall that there, of course, came from the Education and Labor Committee a long series of reports, stacks and stacks of them. Thousands of dollars have been spent—I think Senator Pepper had something like $50,000 for these publications, all of which tended in the same direction, namely, toward compulsory medical care insurance. I believe the committee would have a record of the list of persons to whom those reports have gone through the years. I recall that Mr. Bertram M. Gross had his office in 15–A, Senate Office Building, and bags of stuff went out like this [indicating], great big mail bags, stacked full, sending these reports out all over the country. I think the committee might be interested perhaps in getting a mailing list of the persons to whom the reports from the Pepper committee went. And as I say, a report like this on medical care insurance came out either from the committee—they all came out from the Committee on Education and Labor and from the Pepper subcommittee. During the years a very strong effort was being made to promote the Wagner-Murray-Dingell bill, and then it was thought desirable to see to it that some other informative documents presenting other phases of the full health field be sent out to that same mailing list.

It might also be helpful to find out, perhaps through the Government Printing Office, or perhaps the records of the committee would show, the amount of money that has been spent by the Committee on Education and Labor in publishing these numerous documents, all in one direction. And a document like this is not an inexpensive document.

Senator Donnell. You are now referring to what?

Dr. Shearon. Referring to Senate Committee Print No. 5, which was not passed on by the committee but was printed by the committee.

Senator Donnell. How many pages does it contain?

Dr. Shearon. One hundred eighty-five pages. That is an expensive document. It has been circulated widely. Mr. Falk said that the Social Security Administration purchased 5,000 copies. So it might be well to know how much has gone into this publicity work to publicize the Wagner-Murray-Dingell bill, and that approach to compulsory insurance.

I have here a statement that was put out by a man who writes on labor problems, Chester Wright, labor letter of January 24, 1948, and he calls attention here to the crisis inside the CIO and Philip Murray's efforts to oust the Communists from the CIO and to take away the power of the Communist-dominated labor group. There is listed here a group of 10 unions which are listed as Communist-dominated. This is from a labor publication.

I want to refer to just two of these, the United Electrical Workers—and he mentions Julius Emspak—and the other group is the National Maritime Union, Ferdinand Smith being the man particularly mentioned.

I refer to these two groups because Oscar Ewing invited Julius Emspak to be a delegate to the National Health Assembly, and the National Maritime Union is one of the unions that Mr. Falk, who is the research director, invited to the meeting in the Social Security Building in December 1946. There again, I am just doing this to show the relationship and tie-in with well-known Communist groups.

Now, there is another loose end that was left in regard to Mr. Sutch's statement regarding the insurance program in New Zealand, and I wish to quote just a few sentences from the record, my object being this: When a lawyer wishes to prove that a man is an embezzler or some other type of person who is breaking the law, the lawyer does not have to do it on 100 counts. He makes a very good case on one count, and I should just like to illustrate that Mr. Falk does not tell the truth in a great many instances by giving one or two clear examples.

On page 242 of Mr. Falk's testimony before this committee on January 27, 1948, are remarks with regard to this statement which was written by a member of Mr. Falk's staff, Jacob Fisher, who has been cited about 10 times, I think, by the House Committee on Un-American Activities for his un-American activities. Mr. Fisher prepared this statement for Mr. Sutch of New Zealand to sign, the purpose being to introduce the statement into the hearings on S. 1606 in 1946. The statement was prepared by Mr. Fisher and was sent to Mr. Sutch for his corrections. When in the cross-examination you pressed Mr. Falk with regard to the part that had been played by the Social Security Board in having a statement prepared that was purportedly in line with the views of Mr. Sutch, Mr. Falk says on page 242 of the testimony:

> Mr. Sutch made various and substantial changes in that document in order to conform it to his views and opinions.

Senator DONNELL. Now this is from the statement, the testimony before this committee?

Dr. SHEARON. This is a mimeographed statement of the hearings before this committee on that day, January 27, 1948, when Mr. Falk stated that—and I quote—

> Mr. Sutch made various and substantial changes in that document in order to conform it to his views and opinions.

On the following page, page 243, is a quotation from the letter which Mr. Sutch sent to Mr. Cohen at the time he returned the corrected document. He says:

> I am enclosing my revision of the Social Security statement. You will note that I have not made many changes.

Now, there is the statement by Mr. Sutch to the effect that "I have not made many changes." When Mr. Falk was pressed and he wanted to make a good case he said that Mr. Sutch had made "various and substantial changes."

Now, when one looks at the document that was returned by Mr. Sutch, they were not "various and substantial changes." They were very minor changes. As a matter of fact, there was not a paragraph rewritten. The manuscript was not cut up and changed greatly, as one does if one is making "various and substantial changes" in a document. There were some very small changes where Mr. Sutch improved on Mr. Fisher's poor English with little changes of words. One or two sentences were changed. One sentence was cut out. But otherwise the changes were very minor, as Mr. Sutch says.

I simply wish to call attention to that fact as being the kind of thing that Mr. Falk has done over and over, namely, he twists the truth.

You asked me, Senator, to get the speech that was made by Congressman Harness on February 13, 1948. I have it before me, and it is not necessary to insert the whole thing in the record. The speech is entitled "Address of Congressman Forest A. Harness, Chairman, House Committee on Publicity and Propaganda, before the Conference of Executive Secretaries of the Indiana State Medical Association, at the Claypool Hotel, Indianapolis, Indiana, February 15, 1948." He has a good deal to say about propaganda in general in the Federal Government and the amount of money being spent for it.

Then he comes down specifically to the amount of money being used to take over medicine, and on page 7 he says:

> If the medical profession and all our hospitals can be taken over by the Federal Government and forged into a new and gigantic health bureaucracy, then it would only be a question of time until Washington likewise moved into the field of education, religion, the press, the radio.

Skipping a few paragraphs he says:

> The amazing ramifications of the Federal propaganda in behalf of socialized medicine have astounded me. How much of our total appropriations for health and welfare are being diverted to this sort of high pressure propaganda we do not yet know. But we do know that the amount is considerable, and before our inquiries are concluded we shall hope to present for public consideration an itemized account of the total diversion of Federal funds for this propaganda campaign. In that accounting we shall include a considerable item for foreign travel to New Zealand, England, South America and Japan. For we now know that our health bureaucrats are interested in socialized medicine not only in the United States but in every other land in which they can find an opening.
>
> We now know that the Social Security Board has been spending about $2,000,000 a year in public relations activities, regardless of whether we call it publicity or propaganda.

And so on.

Skipping a few paragraphs I quote again from this speech:

> All this Federally financed activity for socialized medicine heads up to the Bureau of Research and Statistics in the Social Security Board. Our committee investigators have found in that bureau a veritable nerve center of socialized medicine propaganda for the entire world.
>
> Mr. Isidore S. Falk is the Director of Research and Statistics in the Social Security Board. He has been in the Government service for some 12 years. He has always been noted for his militant and aggressive advocacy of compulsory health insurance, commonly known as socialized medicine.

He then refers to the health work shops that they investigated in detail, and he states:

> The detailed operations of the health work shops are set forth in House Report No. 786 of the Eightieth Congress, as published by our subcommittee on July 2, 1947.
>
> Suffice it to say here that the project was financed almost entirely by Federal funds, through the contributions of the participating Government agencies, through the assignment of the so-called forum experts from the Government bureaus, through the payment of travel expenses, and the providing of literature and mimeographed material for the meetings.
>
> The real purpose of these meetings was to generate pressure upon Congress for passage of the Wagner-Murray-Dingell bill.
>
> Following deep into these matters our investigators soon came upon the much-discussed health commission in Tokyo. You have seen reports on this in the newspapers. It, too, is revealing for the light it throws on the operations of the Washington inner circle which is forever pulling the wires for socialized medicine.

He then goes on to give a considerable account, and I do not know that I would care to include this in the record. There will be about four pages. It summarizes what Congressman Harness found. And it is to be noted that on February 15, 1948, after he had had lengthy correspondence with General MacArthur——

Senator **Donnell**. That is, what he found about the Japanese situation?

Dr. **Shearon**. What he found about the Japanese situation is summarized here in three or four pages. It might be helpful to have it in the record.

Senator **Donnell**. I think it should be in the record, in view of the extensive testimony on that subject. It will be included. Mark the portion of the speech which contains that matter.

Dr. **Shearon**. It is pages 10, 11, 12, and 13.

(Dr. Shearon's extract from Congressman Harness' February 15, 1948 address is as follows:)

In our examination of the Bureau of Research and Statistics in the Social Security Board, we discovered that practically every argument, every pamphlet, every radio broadcast, and every statistical table advocating socialized medicine originated primarily in the Social Security Board. Here is the world-wide nerve center of the movement for socialized medicine.

Our committee found, and has so reported to Congress, that pamphlets prepared as to basic material in the Social Security Board were distributed to the general public by the CIO, and AFL, the Farmers' Union, the Physicians' Forum, and the Committee for the Nation's Health. All these pamphlets vigorously supported socialized medicine as embodied in the Wagner-Murray-Dingell bill. In several of the pamphlets, no matter by whom distributed, the language and the figures were the same.

The Social Security Board is the central generating plant, so to speak. And the material is then distributed for popular consumption by whatever organization will lend its official imprint to arguments and briefs of Isidore Falk and Wilbur Cohen. That's the fundamental set-up discovered by our committee, and that's the beginning of the health mission to Tokyo.

In August 1946, a Federal civilian employee from Washington (one Stanchfield) who had been detached temporarily from his job in Washington, moved from Korea to Japan, to make a preliminary survey of social security and health needs. Upon his return to Washington early in 1947, Mr. Stanchfield proposed a general health mission to Tokyo. His proposal was presented directly to Arthur J. Altmeyer, Commissioner of Social Security, not to the War Department.

Next, on March 5, 1947, Mr. Altmeyer outlined the mission in a formal communication to the War Department. In that letter, Mr. Altmeyer designated the particular individuals who should make up the mission, and then went further to suggest that William H. Wandel, Chief of the Program Division, Bureau of Unemployment Security, be appointed chief of the Social Insurance Division of the Public Health and Welfare Section of the Supreme Command for the Allied Powers in Tokyo. It is perfectly apparent from the letters we have taken from the War Department files that the personnel of this mission and the planning of its program originated in and was dictated from the Social Security Board in Washington.

Up to this point there had been no hint that the proposed health mission had been requested or urged either by General MacArthur or any responsible Japanese source. The suggestion came first from Mr. Stanchfield, who had been sent to Tokyo for that particular purpose.

Next, we found a letter, under the date of June 14, 1947, from Mr. Wandel in Tokyo reporting directly to Mr. Falk in Washington on the progress of the work in Tokyo. In one revealing passage of this letter, Mr. Wandel said:

"We think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan * * * Permanent revision requires amalgamating National Health Insurance with Health Insurance on a compulsory basis."

When the Tokyo health mission finally was named, it comprised two men from the Public Health Service, one from Mr. Falk's Bureau, and one from the Federal Housing Authority. This mission departed for Japan on August 28, 1947, with the understanding that Mr. Altmeyer and possibly Mr. Falk would follow when the work had been sufficiently organized in Tokyo.

One of the members selected for the Tokyo mission was Dr. B. M. Davis, who is the son of Michael M. Davis, chairman of the executive committee of the Committee for the Nation's Health. This Committee for the Nation's Health is perhaps the most conspicuous lay organization agitating for socialized medicine in the United States. The father, Mr. Michael M. Davis, long has been a coworker with Messrs. Altmeyer, Falk, and Cohen in the national and international agitation for Socialized Medicine.

It is significant, also, that the son, Dr. B. M. Davis, was, at the time of his selection for the Tokyo mission, on duty in England, temporarily detached from his Governmental job in Washington, to assist in perfecting legislation in England for the complete socialization of all hospital and medical care in that country.

We thus find Dr. Davis barely finishing his assignment in England in time to catch the Tokyo assignment.

It is true that Dr. Davis is a member of the staff of the United States Public Health Service. He is a Government employee of the United States, but the record shows that during the past 18 months his principal duty has been in perfecting medical legislation in other nations—first in England and next as a member of the mission to Tokyo. After a brief stay in Tokyo, he returned to England to assist on the final phases of the British program in Parliament.

Because this instance offers a shocking demonstration of bureaucratic intrigue in violation of the purposes and the intent of Congress, I brought the matter to the attention of the House Appropriations Committee, with the suggestion that when the next budget comes up from the Social Security Board and the Public Health Service, funds for all those engaged in spreading socialized medicine around the world be stricken from the appropriations bill unless, of course, Congress shall determine to support such world propaganda with funds specifically alllocated for that purpose.

In my letter to Chairman Taber of the Appropriations Committee, I made eight specific charges against the Tokyo health mission. I wish to summarize them here, because they are the nub of our case against the Social Security Board and the United States Public Health Service in relation to all this propaganda supporting socialized medicine.

My charges against the Tokyo health mission are as follows:

(1) That the health mission to Japan was composed entirely and exclusively of men long identified in the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.

(2) That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.

(3) That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.

(4) That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by Federal employees sent from Washington for that particular purpose.

(5) That Gen. Douglas MacArthur does not favor—and does not approve—any plan to establish compulsory socalized medicine in Japan.

(6) That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk under date of June 14, 1947, is a gross misuse of public funds.

(7) That the real purpose of the mission was not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.

(8) That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved.

It is a matter of public knowledge that the health mission to Tokyo has now returned to the United States. They came back, be it noted, before Messrs. Altmeyer, Falk, or Cohen joined them in Japan.

We are assured from certain events in the public record, that our subcommittee's letter to the House Appropriations Committee, under date of September 9, 1947, had a decisive influence upon the course and actions of the Tokyo health mission. Once the full light of public inquiry and understanding had been focused upon the mission, it soon became a different sort of thing.

You will be happy to know that General MacArthur has not acted on the recommendations submitted by this mission, but has referred them to the American Medical Association in Chicago for consideration and advice.

I wish that I were free to give you at this time the details of the communications that have passed between myself and General MacArthur on this transaction. I cannot properly do so, however, until the final report of our subcommittee. Suffice it to say here that General MacArthur refused to act on any of the mission's recommendations until they had been weighed and evaluated by the American Medical Association.

I deem it inappropriate for Federal employees, at the expense of the American taxpayer, to travel throughout the world preparing or assisting in the preparation of legislation to be adopted by foreign countries when similar legislation, long pending, has not been approved by the Congress of the United States.

But the issue is even broader than the question of socialized medicine. It is also challenging in that it reveals for public examination the manner in which all Government lobbyists operate on the Government pay roll, how they are always at work to expand their fields of interest, to perpetuate themselves in office, and to impose their ideas and systems upon the American people by organized propaganda paid for entirely by the diversion of public funds from their true purposes to the shielded purposes of the top bureaucrats and planners.

This is the fundamental issue from the legislative standpoint—the question whether the Congress of the United States has lost its power to establish and maintain the sort of Government the people want; or whether the bureaucrats are supreme and can give the sort of Government they want, regardless of Congress, regardless of elections, regardless of public opinion.

That's a question that goes to the very roots of popular Government. If the bureaucrats are above Congress, and may defy Congress in the way they spend their appropriations, then representative Government has become a fiction.

I am certain that the United States has not yet reached the point where it must be submissive to the dictates of a rampant bureaucracy in Washingon.

Our assignment is a challenging one, for it is often very difficult to separate the merits of pending legislation from the larger question of Government propaganda designed to provide a sytem of national thought control.

Dr. Shearon. I have just one or two supplementary things to say on that Japanese mission. The attempt was made by Mr. Falk and by Mr. Cohen, who it is to be remembered is the technical adviser to Commissioner Altmeyer and the assistant director under Mr. Falk—the attempt was made to make it appear that this mission to Japan was entirely proper, that the request for the mission came from General MacArthur, that the planning was done in Japan and not here. It was a very plausible statement, but it was not quite in accordance with the facts, and I want to refer to the letter that Commissioner Altmeyer wrote. This is a photostat from the War Department files—I have the complete file, and I refer to the letter which he wrote on March 5, 1947, to Maj. F. B. Simmons in the War Department. Prior to that time he had been approached by a Mr. Stanchfield, whom Congressman Harness referred to. Mr. Stanchfield was formerly associated with William Haber, who was formerly—or is, as a matter of fact, on the staff of the University of Michigan and was loaned to the Federal Government during the war. He is a member of the Committee for the Nation's Health, and he is one of the signers of this document that we have referred to so often as the document that was put out by Michael M. Davis and this same Committee for Research in Medical Economics. William Haber is one of the signers of this document which is one of the most powerful lobbying documents used in this propaganda.

Senator Donnell. Is that "Principles of the Nation-wide Health Program"?

Dr. Shearon. Yes. Mr. Stanchfield had formerly been associated with Haber, and it was Stanchfield who was sent over to Japan to size up the situation, and who came back and had this informal talk with Mr. Altmeyer, and then Altmeyer said that he would be willing to head up a mission to Japan. In this letter he is the one who states whom he wants to have sent to Japan. At that time General MacArthur unquestionably knew nothing about it. This initiated here in Washington. As a matter of fact, they even had copies of envelopes on which the names were jotted down, the names of the people that they wanted to have sent over to Japan, and Altmeyer states :

"I will be accompanied by Mr. Wilbur J. Cohen." He then says: "I would want William H. Wandel, Chief of the Program Division, Bureau of Employment Security"—that is in Social Security—"to serve on the mission."

In other words, he selected the top people for the staff, and from that time on there were numerous developments which have been brought out in the testimony.

A great point has been made of the fact that General MacArthur said he had no idea of wanting socialized medicine in Japan. Of course, he did not. No one ever said he did. But the fact remains that this group that did the planning in Washington was picking out only people who had worked for the socialization of medicine—"nationalization" as I prefer to call it. General MacArthur did not know anything about this planning at all, and he said he did not know these people who were selected; that he had asked for some professional assistance, and assumed that if they came through the War Department they would be well-accredited people.

Mr. Cohen mentioned the fact that he could not get help, could not find people that wanted to go to Japan. He inquired only among a very small group. There were plenty of other experts in this country in the field of health insurance who might have been reached with the request to go to Japan, but all he did was to reach the little group, the little clique inside the Government that had been working for nationalization of medicine all these years. He never got in touch with me, for instance, to ask me if I would like to go to Japan. I am an expert in the field. And he did not get in touch with other persons who have left the board, who were experts in the field, and well-recognized experts. So I say he kept his inquiries in a very small field.

I should like to point out another thing that has not been brought out, namely, that before this mission actually went to Japan on August 28 I received a call from a physician in Montana who had been with the Surgeon General in the War Department during the war. He was very much worried about this whole situation and asked me if I would get in touch with Colonel Doane, who was on the staff of the Surgeon General. I called Colonel Doane and he said he was very glad I had called him; and he had already had word from Montana that I would call, and he said: "We in the Surgeon General's Office do not know anything about a mission. We do not know anything except what we read in the newspapers. We have not been consulted."

Now, I submit that was hardly proper procedure when General MacArthur asked the War Department to give him some help in the medical field. One would naturally think that the first thing to be done would be to notify the Surgeon General of the War Department.

Colonel Doane then asked me if I would send him any information that I had, so he might be brought up to date. I sent him all the information I had, and gave him the name of Congressman Harness, and he got a great deal of information, and subsequently representatives from the War Department went to Japan and they told the story of what had happened, and it was perfectly clear that General MacArthur was not involved in any way, had no intention of doing what these officials in Washington were trying to do, namely, putting over a Wagner-Murray-Dingell bill in Japan if they could do it. When the scheme was exposed, and when these things were brought to light during August by Congressman Harness and by myself, the picture changed. These people were not so anxious to go to Japan, and the mission actually broke up and few of them went. Four of them went, but when Mr. Sanders, who was one of those who went—he is attached to Mr. Falk's staff—came back and was asked what he had accomplished, he said he did not know if he had accomplished anything for the Government, but he had had a good time himself. And, of course, the taxpayers paid for it. The whole thing, as a matter of fact, collapsed, and in the end, after the picture was made perfectly clear and exposed to the white light of publicity, when this group in the Federal Government made its recommendations to General MacArthur, he turned the recommendations over to the American Medical Association for expert advice in the medical field.

That is all I have to say on that subject, but it makes it very clear that the statements which were made by Mr. Cohen and Mr. Falk did not give quite the entire picture.

I should like to introduce into the record a letter from a Dr. Curt Steffen. He is an M. D. and also a Doctor of Public Health and a Fellow of the International College of Surgeons. I should like to introduce both the letter which he sent to me, dated March 28, 1948, and an article which he had published in the Social Service Review, volume XXI, No. 3, September 1947, entitled: "Medical Care Under Compulsory Sickness Insurance in Germany."

Senator DONNELL. What is the general subject matter of the letter to which you refer? I do not mean for you to read the letter, but on what subject is it written?

Dr. SHEARON. The subject of the letter is this article which I came upon. I was very much interested in the first footnote of the article which says: "Prepared at the request of the United States Senate Committee on Education and Labor."

Senator DONNELL. Which article is that?

Dr. SHEARON. This is the article by Dr. Steffen on Medical Care under Compulsory Sickness Insurance in Germany. The footnote says it was prepared at the request of the United States Senate Committee on Education and Labor. So I wrote to Dr. Steffen and asked him what had become of this article, which is a very interesting and illuminating one, on what happened to Germany under medical care insurance. The reason I want the letter inserted is that he explained that when he wrote this article, and he was a man well qualified to do so, since he had had 20 years of actual experience on the spot, and for the last 10 of those years had been the physician-in-chief of Compulsory Sickness Insurance in Hamburg, Germany, he said he felt obliged to show both sides of the picture. Apparently in his conclusions he did not come out with the right answers and the material was not used. I point this fact out to show that we are getting a great deal of biased information on this subject, and we are not getting at the facts.

Senator **Donnell**. I notice the concluding sentence of his article which appears in the Social Service Review, Volume XXI, No. 3, September 1947, reads as follows:

> For all those apparent reasons, it is unpredictable whether a system blueprinted or redesigned after the German pattern, requiring expenditures of about eleven to fourteen billion dollars annually, for instance, for a like American program, large numbers of Government and State officials, strict bureaucratic control, and regimentation as a *conditio sine qua non*, will operate smoothly and efficiently in nations with completely different social economics, traditions, and ideologies.

Now, which is it that you are offering?

Dr. **Shearon**. I am offering both the article and the letter. The reason I am offering this letter—the principal reason—is that in the first paragraph he says:

> On October 16, 1946, I received a letter signed by Joseph P. Murray—

he must mean McMurray, because he was a clerk of the committee—

> special assistant, that my report will be brought to the attention of the Senator.

He had been asked by Senator Murray to write this report.

> Since then there was silence all over.

He still writes English with a somewhat German phraseology, but it is very descriptive—"since then there was silence all over." He has not heard anything more of this report.

Senator **Donnell**. The report and letter will be placed in the record in full.

(The letter dated March 28, 1948, and the report dated September 1947, follow:)

Curt Steffen, M. D., F. I. C. S.

Mrs. Marjorie Shearon,
Washington 1, D. C.

Dear Dr. Shearon: Thanking you very much for your letter of March 24, 1948, I would like to inform you that in 1946 I was asked by Senator Murray to submit a study on compulsory health insurance. On October 16, 1946, I received a letter signed by Joseph P. Murray, special assistant, that my report will be brought to the attention of the Senator. Since then there was silence all over.

Having had 20 years' actual experience on the spot, the last 10 years as the physician-in-chief of Compulsory Sickness Insurance in Hamburg, Germany, I felt obliged to show both sides of the picture: The advantages for the German people and the enchainment of physicians and patients, which is a *condition sine qua non* of Compulsory Sickness Insurance. My 10 years' experience as a practicing physician in this country taught me that in order to keep the expenses of such a system bearable even for a wealthy country it would require a much tighter enchainment here than in Germany. Just lately the V. A. Administration had to clamp down on patients as well as on the doctors. The request for medical treatment in this country is much greater than the one in Germany. People here buy medical care as they buy anything else. If they would not have to pay for it and for drugs they will buy quantities of them nobody will be able to pay for. People here are much more used to insurance and would try to get as much out of it as possible. The same is true to physicians, who practice here much more on a competitive basis than in Europe, everyone of them would strive to get as much out of this system as possible too. Finally the hospitals here are mostly privately owned, the druggist and the many merchants connected with such a system would try to get their share out. This all has to be supervised or the state will go bankrupt very soon.

Since I realized very soon that enchainment is the worst you can do to the American people I came out in strong opposition to the introduction of a compulsory health insurance system here although I am a member of the Democratic Party.

Now you probably understand that nothing was done with my report nor with my article. I believe that if you could bring it to the attention of the opponents of the Wagner-Murray bill a lot could be done with this report, since it is one of the few authentic reports on a compulsory sickness insurance system written not by an American physician travelling through Germany but by a man whose former career was compulsory sickness insurance and has been recognized as an expert in this branch by the German Government as well as by the International Labor Committee in Geneva.

Appreciating your kind letter the more since I did read most of your scientific articles.

I am always at your disposal.

Yours,

Curt Steffen.

[Reprinted for private circulation from the Social Service Review, vol. XXI, No. 3, September 1947]

Medical Care Under Compulsory Sickness Insurance in Germany, Curt Steffen, M. D., D. P. H., F. I. C. S.

This study[1] of the German compulsory sickness insurance is based on 20 years of practical medical experience[2] from the three medical viewpoints involved.

The purpose of this study is not to advocate the adoption of the German system in other countries but to present the facts regarding the German situation during the normal years.

Organization.—The compulsory sickness insurance in Germany covers twenty million members plus fourteen million dependents, almost half the entire population. It is supervised by the Ministry of Labor and administered by a special government office (*Reichversicherungsamt*) with branch offices in every province (*Landesversicherungsamt*). It is composed of different statutory bodies: the largest is the general sickness fund (*Allgemeine Ortskrankenkasse*), for workers and employees who do not belong in one of the following special categories; the industrial sickness fund (*Betriebs Krankenkasse*), operated by the individual plants; the sickness fund of the guilds (*Innungs Krankenkasse*), for special workmen's guilds; the miners' fund (*Knappschafts Krankenkassen*), for the miners; the seamen's sick fund (*See-Krankenkasse*), for the merchant marine; and the farmers' sick fund (*Land Krankenkasse*), for farmhands. Such a decentralization has been proved superior to one giant centralized sick fund because it guarantees a certain autonomy of its administration exercised by employers and employees knowing the requirements of their respective labor groups by their own experience. Furthermore, it has been found more flexible in adapting the insurance benefits to the special needs and more economical than one unified mammoth sick fund, serving all the various types of wage- and salary-earners.

Criterion for membership in all these sick funds is an income not exceeding $1,200 annually for the individual wage- or salary-worker. For these, membership is mandatory and goes automatically with employment on a pay-roll deduction plan, two-thirds paid by the employee and one-third by the employer, the insurance premium varying between ⅜ percent of the basic wage. It guarantees the "right" to complete coverage in case of illness or accident for a period of twenty-seven to fifty-two weeks in each year to the member and his dependents. In case these weeks are exceeded, government relief takes over automatically and indefinitely. The same benefits are secured by the government to the unemployed and administered by the C. S. I. system.

Benefits.—The main features of the compulsory sickness insurance are the different cash benefits. Compensation for loss of wages is assured the sick or injured worker and his dependents, payment being made at the rate of 50–60 percent of his average wage for a maximum of 26 weeks yearly. Maternity benefit at the same rate for 10 weeks and death benefit fifty times the daily wage also are a part of the program.

---

[1] Prepared at the request of the United States Senate Committee on Education and Labor.

[2] For five years—1918–23—I treated the so-called "panel" patients in different university hospitals in Hamburg and Berlin in my capacity as a resident gynecologist; for ten years—1923–33—I supervised the entire medical panel service in Hamburg as a physician-in-chief of a medical staff consisting of thirty-five certified specialists; and for five years—1933–37—after having been ousted from this public office by the Third Reich, I was a panel physician myself, specializing in obstetrics and gynecology.

The system furnishes the following medical services: (1) physicians' service, including general practitioner, specialist, dentist; (2) nursing service, including institutional nurses, midwives, home nurses, and visiting nurses; (3) diagnostic laboratories and X-ray services; (4) supply of drugs, diets, glasses, and other medical appliances; (5) physical therapy, including radium and X-ray treatments; and (6) hospitalization in general and special hospitals, mental hospitals, sanitariums, and convalescent homes.

The insured and his dependents have an unlimited free choice of physicians, specialists, and hospitals, with almost 90 percent of all physicans and hospitals participating voluntarily in the program. Services of specialists are directly available to the patient without permission of the attending practitioner. The patient is not assigned to a doctor, specialist, or hospital by anyone, he need not select his physician in advance, and he may change doctors at any time. If the patient desires extra service in a hospital, such as a private room, private nurses, etc., he pays only the additional cost of such specialties. These are asked only in exceptional cases.

Medical and hospital service.—The quality of medical service available through the C. S. I. depends largely on the quality of the physicians and hospitals rendering medical service. Since almost 90 percent of the entire medical profession participates in the program, panel physicians do not constitute a special class within the medical profession. All physicians come from medical schools of the same grade, since there are no unapproved medical schools in existance. All universities are state owned and have the same educational standards set up by the government. In prewar days the medical schools of all universities were recognized as Grade-A medical schools by the American Medical Association. Internship has been required for at least the last twenty-five years, and about 80 percent of the physicians have had one to two years' postgraduate training (residencies in approved hospitals) following internship. All panel physicians are required to hold membership in the German Medical Association with its strict code of medical ethics. All specialists on the list of the C. S. I. must be certified by a governmental statutory body (*Reichsärztekammer*) and must offer proof of two to seven years of full-time residence at an approved hospital, the length of time depending on the individual's medical specialty. This certification of specialists has been in force for the last twenty-five years. No osteopath, naturopath, chiropractor, optometrist, foot specialist, or any other nonmedical practitioner is eligible for the C. S. I. practice; none of these can style himself as a "doctor," since the only one existing is the M. D. (doctor of medicine) of the licensed physician and surgeon. The title "physician" (*Arzt*), as well as the title "M. D.," is protected by law and is bestowed by governmental authority only. The doctor is not forced into the C. S. I. by legislation, but his participation is more or less an economic necessity. He is on a fee-for-service basis, the fee schedule being made up by the C. S. I. in a contractual arrangement with the medical society, similar to the agreement between the Veterans' Administration and the state medical societies in our country. He gets his remuneration directly from the medical society and is not allowed to accept any extra payments for his services from panel patients. Therefore, fee-splitting—or a rebate from any source—is not practicable inasmuch as the bulk of surgery is performed by hospital physicians, paid by the municipalities. The physician can take as much panel practice as he wishes; he can reject patients; and he is unrestricted in his private practice. The proportion of his panel work depends on his location—whether in an industrial or a residential district. Very few doctors devote themselves exclusively to panel practice, and few are engaged exclusively in private practice. There is no interference with a doctor's political concepts or his medical practice so long as he complies with the statutory provisions laid down by the C. S. I. and his local medical society.

The ratio of physicians to the population averages 1 to 1,200 compared to 1 to 854 in the United States, and, in spite of this low ratio, the C. S. I. never felt a shortage of physicians, because of the leveling effect of panel practice and the better distribution of physicians in rural and poorer districts. The C. S. I. is bound to increase the earnings of physicians, dentists, and druggists whose fee-for-service payments, although much smaller in the individual case than in private practice, are guaranteed by the government. Without the C. S. I., 50 percent of the patients in the hardship-level group would not be able to consult a physician, and a high percentage of the rest would not be in a position to pay for his services. Therefore, in spite of the very low rates paid to the physician, the average annual pre-war income of physicians was as shown in Table 1.

The amount of panel practice the physician actually gets—since no limit on the number of the patients he may treat is set up—depends, as in private practice, upon his initiative, personal qualifications, and professional reputation. For the young physician, located in a predominantly panel area, it means a chance of getting a start, together with the opportunity of building a private practice through recommendations, by his panel patients to private patients. At the same time, the C. S. I. leads to fuller occupation of the average physician, since the number of minor ailments brought to his attention is higher on account of the removal of the financial barrier between the patient and the physician. For the same reason the physician may care for many more routine cases, referring those which require more attention to the specialist or to the hospital. He will not lose his patient by this procedure, since the specialist is strictly limited to his specialty and both of them receive their fees from the C. S. I. The result is that the panel patient actually gets more specialized service than the average private patient can secure and that the general practitioner works in closest cooperation with the specialist. This type of medical practice is considered superior to group practice by the German Medical Association, which claims that the best and certainly the cheapest medical care is given by the general practitioner, who has the confidence of his patients and knows their background. Other factors that allow the panel doctor to handle more cases in his office and to make more house calls are that he has no charity cases and that he has very few hospitalized patients under his care. This latter is due to the nation-wide hospital organization, which is based on a predominantly public system. Being true community hospitals, they provide care for people from all walks of life: 60 percent of their beds are occupied by C. S. I. patients, 33 percent by relief patients, and 7 percent by private patients.[3] Eighty percent of the panel patients requiring hospitalization are treated in municipally owned institutions, which have closed staffs or specialists. These men work on a salary basis, whereas the panel physician is not paid by the C. S. I. for hospital work. Since these salaried hospital physicians are the leading men in their specialty and include most of the university faculty members, the patient is assured the best medical and surgical care available in the country. These well-qualified men, having no financial interest in the case, likewise protect the patient from exposure to incompetent and unnecessary surgery.

TABLE 1

Average annual income of panel physicians: [1]	*Percentage of Panel Physicians Receiving—*
$2,000	56.5
$2,000–$4,000	23.5
$4,000–$6,000	12.0
$6,000–$8,000	4.5
$8,000 and over	3.5

[1] To these figures must be added income from the unlimited private practice.

Many municipally owned hospitals, which maintain 80 percent of all the hospital beds in the country, may seem to be antiquated in their architectural design, just as are many government and county hospitals in other countries, due to the fact that they are not built and managed by private enterprise under competition. But their equipment is up to date, and the quality of their medical service, for the reasons given, is the best available in the nation. All hospitals are guaranteed freedom in the management of their affairs and have only a contractual arrangement with the C. S. I. concerning the fee for the daily occupation of a bed, half of which is paid by the C. S. I., the rest by the government, state, city, or municipality. Those large governmental hospital subsidies must be added to the two billion reichsmark expenses each year for the C. S. I. system.

Administration.—With such vast public revenues involved, a large bureaucratic machine with an average cost of 7 percent of the entire C. S. I. budget (one sick fund employee to seven hundred insured members) has been proved necessary by experience over many decades to check abuses—not only on the part of the insured tempted to demand more attention than he requires but on the part of the panel doctors distributing public funds and tempted to add to their income by rendering unnecessary services. So far as the patients are concerned, the cash benefit is tempting, particularly in times of depression, unemployment, strikes, and on holidays. Therefore, the patient's disability, if carrying a cash benefit, is rechecked by a physician (*Vertrauensarzt*) employed on a salary basis by the local branch office of the sick fund or in larger cities by a medical board of consultant specialists, working on the group-practice principle (*Vertrauensarztstelle*).[4] Those medical attachés of the C. S. I. work in close co-operation with a staff of trained lay inspectors who visit most of the disabled patients at their homes and report all who apparently are not actually disabled for reexamination by the medical board. They combine this policelike function, necessary to control absenteeism, with other activities such as checking the patient's home environment, advisability of hospitalization, necessity of home nursing, etc. The absolute necessity of this supervisory procedure becomes evident from the result of such reexaminations. According to my own statistics,[5] 37 percent of 35,000 patients reexamined each year over a ten-year period were found not incapacitated to work. If to those figures the number of disabled patients who return to work voluntarily without reexamination is added, it has been shown that about 60 percent of the patients receiving sickness cash benefit are actually not incapacitated for work. There are other restrictions on the patient, such as his contribution (10–20 cents) for a slip (*Krankenschein*) which entitles him to see the doctor, and the same amount for a prescription. Those regulations were introduced more than fifteen years ago to curtail unnecessary sickness claims and the use of drugs for trivial complaints.

---

[3] Monograph (in German) dealing with hospital facilities, by Curt Steffen, M. D. (published by the Board of Health, Hamburg, 1930).

With regard to the panel physician, certain restrictions were also found necessary to check abuses. The entire medical service is statistically supervised by a board composed of the local C. S. I. branch (*Krankenkasse*) in co-operation with the local medical society. It includes a periodical survey of the cash-benefit slips and prescriptions issued by the doctor, the number of hospital cases, office visits, and house calls. In case the individual doctor regularly exceeds the average of his colleagues in his district, he may be forced to accept a reduction of his monthly remuneration, or, if he continues this abuse of public funds, he may be disqualified from further panel work by the board.

He also is supervised by a medical board attached to the C. S. I. with regard to hospitalization of his patients. Except for emergency cases, hospitalization must be endorsed by the board before admission, in order to avoid unnecessary hospitalization. He is also limited in his prescriptions to a list of drugs approved by the C. S. I. and the local medical society, to prevent nonessential high-cost medication and patent medicine.

In general, it is safe to say that the panel patient does not receive luxurious medical care—for he does not have any but the most necessary diagnostic laboratory tests and he does without X-ray examinations and fancy drugs—but he gets all the essential medical, dental, and hospital care needed to restore his health and to send him back to his job in the shortest possible time. The panel patient seems to be satisfied with the medical service rendered, since only a negligible number consult nonpanel doctors, nor does he visit the very few cultists and quacks existing in Germany or seek refuge in patent medicines, which are almost unknown.[6] The doctor is not burdened with paper work. It does not exceed that required in private practice, although he is obligated to keep thorough records of his cases, which are registered with the C. S. I. administration. This medical record (*Krankenkarte*) accompanies the patient from the cradle to the grave and represents an invaluable life-chart for the administration as well as for all attending physicians and hospitals. This is a confidential record, considered "privileged communication" and protected by a special law (*Schweigepflicht*), which is strictly enforced not only on doctors, nurses, and medical secretaries but also on all lay employees of the C. S. I.

Preventive medicine.—The C. S. I., realizing that the prevention of disease is the most economical and effective policy, has played an outstanding role in preventive medicine. The compulsory insurance principle, per se giving almost half the population free access to every type of medical service, is bound to increase the demand for medical service and to result in an earlier diagnosis and treatment at a time when the latter is more effective. Therefore, the C. S. I., closely linked with the public health organization, took an active part in any prophylatic campaign enabled by numerous laws to force the issue of prevention. Where public clinics were maintained, the panel patients were referred to them. In the larger cities, the sick funds conducted their own clinics for tuberculosis, venereal diseases, birth control, cancer, varicose veins, and mental hygiene. They also built modern orthopedic institutions for the treatment of spinal deformities in children, rheumatic and arthritis sanitariums, solaria to control rickets and scrofula, milk kitchens for ultraviolet irradiation of milk, X-ray departments for routine chest examinations, inhalatoria, large physiotherapeutic departments, lunchrooms for under-nourished children, diet kitchens, vacation homes in the forests and on the sea-beaches for the the city youth, convalescent homes for overworked laborers. These modern establishments were considered exemplary in the field of prevention by the Hygiene Commission of the League of Nations, on the occasion of an inspection tour of this international body in 1931. Thus, in 1930, the C. S. I. in Hamburg offered for the first time in the world a free periodical examination to all women to control cancer, with the result that 10,000 women attended this public Cancer Prevention and Detection Clinic yearly.[7]

---

[4] Curt Steffen, *Das Hamburger Vertrauensartzsystems* (*Berliner Aertzte Correspondent, 1931*).

[5] Steffen, *Einwirkungen der Wirtschaftskrise auf den Gesundheitszustand der Versicherten* ("Deutsche Krankenkasse," No. 30, 1932).

[6] No drug whatsoever may be sold by a pharmacist without a doctor's prescription, eliminating self-medication completely.

All venereal diseases among panel patients were reported routinely by the administration to the health department, and compulsory treatment was required by law. This led to such a low rate of venereal disease in pre-war Germany that the medical teachers had trouble in finding early cases of syphilis, even in an international harbor city like Hamburg, for demonstration purposes. In seaports special venereal clinics for the merchant marine were in operation, and the diseased seamen were quarantined. Smallpox vaccination, made obligatory by law, was carried out by the C. S. I. Every member of the C. S. I. received free of charge a magazine for health education monthly and was entitled to a free physical examination by the board of consultants at any time. It is superfluous to say that the strict German health laws, the "must" behind all regulations of the C. S. I., and the respectful attitude of the overdisciplined German people combined to make this vast preventive program successful.

General health standard.—The C. S. I., therefore, deserves credit for the comparatively high standard of health and medicine in pre-war Germany. Since there are no better judges on this topic than medical representatives of the leading nation in world medicine, I refer to our own experts and their opinion on German medical standards.

Dr. Morris Fishbein of the A. M. A. spoke of the "Medical World Center" in Berlin, which he wanted to see taken over by Chicago. Dr. W. V. Kennedy wrote, "No one will claim that lower standards of medical training are the rule in European countries."[8] Colonel Edward D. Churchill, Allied Mediterranean forces surgical consultant, wrote of "German medicine's world-wide pre-Hitler fame and Germany's once proud position as world leader in medicine and surgery."[9] Lieutenant Colonel Richard L. Meiling, who toured Germany after this war, wrote in the United States War Department's publication for 1945: "The national medical and health organization of Germany was perhaps the most thorough, powerful, closely knit body for the control of a nation's health the world has even seen." The same War Department report credits the well-organized public health service for the absence of epidemics expected as a result of the vast destruction of German cities.

Thus, the deterioration of Germany's former outstanding tradition in medicine can hardly be blamed on its C. S. I. system. Rather it is the logical consequence of the Nazi philosophy, which seeped through the nation after 1930. From that time on, medicine undoubtedly deteriorated rapidly because the Third Reich was not interested in medical training, medical research, and medical scientific knowledge. Its only interest lay in military preparation for the impending conflict, and the result was a complete medical collapse.

Alternative systems.—Why did the different German governments adhere to the compulsory approach? The explanations are obvious. No German government was able to promote an economy that provided a standard of living on a level where medical care could be provided by private medicine to the lower-income groups. Charity practiced only on a small scale is not popular with the German people. The relief system, with its requirement of a "means test," is also unpopular. That leaves only one alternative—prepaid voluntary sickness insurance. Private insurance in the field of sickness plays only a minor role in Germany and serves mostly the middle- and upper-income groups. It could not cope with the extensive C. S. I. system for many reasons. The German, in general, is more likely to look to a governmental authority for protection than to rely on privately owned institutions. The private sickness insurance plans in Germany actually do not and cannot give the comprehensive coverage of the national C. S. I., or, in case they do, their premium rates are far beyond the financial capacity of those in the $1,200 annual-income group. Their plans are generally restricted; they operate on a profit basis; and, therefore, they try to get the better risks. Except for a very few operated on a cooperative basis, they fail to give any representation in their administration to the policyholder. Their fee schedule is not obligatory on the hospital or to the attending physician, and adequate compensation for loss of wages is seldom provided. It goes without saying that the hardship-level group, due to the continuous struggle for the necessities of life, is the least likely to buy sickness insurance voluntarily.

---

[7] Professor H. Hinselmann, *Einführing in die Kolposkopie* (Hamburg: Paul Hartung, 1930).

[8] *American Medical Association Journal,* CXXXI, No. 3 (1948), 327.

[9] Reprint of the National Physicians' Committee for the Extension of Medical Service, 1945.

Summary.—The national compulsory sickness insurance system in Germany until 1947 limited strictly to the lower-income groups, has groped its way methodically for many decades, mainly on account of the typical German philosophy of life. A traditional connection with the name of Bismarck did its part to make it an integral component part of the German national structure. This tradition and the inability of alternative systems to render complete coverage to the indigent seem the main reasons for the political support of the system in force by the majority of the German political parties. It is an economic necessity for the medical profession. Even the Nazi regime, which tore down the Weimar Constitution, realized the impossibility of a retreat from the elaborate C. S. I. system and kept its destructive hands off this powerful political weapon Still, there were many objections to its operation, not so much to the compulsion and economically necessary regimentation, but to the steady rise in expenditures, which surpassed two billion reichsmark annually, not including the vast government subsidies to the hospitals. This was in spite of the attempts of German social economists to carry this cost on the credit side of the nation's budget, reassuring its return in the form of manpower efficiency and national health. But the C. S. I. never ceased to be a storm center for all groups involved, requiring constant change in its laws and regulations. The employer group fought continuously for cuts in appropriations for administration, including medical services; the insured group hoped for further expansion of medical care and increased compensation for loss of wages; the medical profession wanted higher remuneration; the sick fund civil service employees worked for an increase in salary; the different C. S. I. branches wished for hegemony within the C. S. I. system, with the government in the middle. Even strikes of the panel physicians could not be avoided, and yet nobody could check the alarming rise of the operating cost of the system, originating mainly from the steady increase of morbidity (from 28.6 in 1923 to 55.4 in 1934 per one hundred insured), from the prolonged duration of incapacity (from ten days in 1923 to fourteen days in 1934), and from the increase of the period of hospitalization (to an average of twenty-eight days in 1934), according to my own statistics published in *Social Medicine* in 1934. Whether those figures should be considered an unfavorable aspect of the system itself appears questionable, since the growing industrialization, economic depression, lack of housing and employment, aging population, and many years of social unrest may be contributory factors, inasmuch as comparative figures on a like large scale from other countries are not available.

In general, it is safe to say that the C. S. I. system, being in operation up to the present time, has contributed substantially to the care and welfare of the medically indigent in Germany. In nations where freedom is the highest ideal of the people and a natural antipathy to coercive measures is prevalent, a compulsory approach to meet an existent health urgency seems to be justified only if it cannot be avoided. This is especially true if such a system is planned to be forced on a large part of the population, which does not belong strictly in the "needy" category.

In what may perhaps be described as the "have not" nations, the government will be confronted with an acute imperative health need of a medically indigent group, the size of which will be in direct proportion to the national economic level. In case this needy group constitutes such a large part of the population that funds for medical services cannot be made available from public revenues, compulsory sickness insurance may be necessary. It then should be for the population as a whole and not for the lower-income group or to a part of the population only, since it must be supported by taxation. Such a national C. S. I. system—being no more than a refined and nobler type of public assistance—on the other hand, means more or less socialization and nationalization of medicine. The latter has been made complete lately in the Russian zone of occupation in Germany. By decree of the Soviet Military Government on January 28, 1947, the unification of all insurance branches into one social insurance board (*Sozialversicherungsanstalt*) covering sickness, maternity, invalidity, old age, and unemployment, has been established, and the foregoing coverage has been made compulsory for all wage-earners, employees, and even employers not employing more than five employees, permitting the rest of the citizens to join voluntarily without any income limit.

No justification for such a social order which may constitute the only realistic approach to the reconstruction of the impoverished German people can be seen for a democratic nation with a high standard of living.

In case the number of persons living on a precarious subsistence level is comparatively small, the public-assistance approach seems to me preferable to the compulsory insurance system for the following reasons: (1) The former, financed by public funds, will be needed, in any event, to supplement the C. S. I. system on account of the limitation of its benefits. (2) It distributes the cost of sickness of the medical "have nots" evenly over the entire population and does not change the whole system of the practice of medicine. (3) It shares the psychological factor of the means test with the C. S. I. system because the panel patient is more or less stigmatized, too, by belonging to a low-income group. (4) It is much simpler and less costly to administer than an expensive compulsory insurance system, particularly in nations operating other branches of social insurance or public assistance. (5) Last, but not least. it lacks the unpopular compulsory approach. The adequacy of the medical services to be provided depends solely on the contractual arrangements to be made by the government with the medical profession, hospitals, dispensaries, public clinics, etc. A government of a prosperous nation with a stabilized economy should be financially able and should feel socially obligated to set aside adequate appropriations from its tax revenues to grant every needy citizen the right to all necessary preventive and curative medical services.

For all those apparent reasons, it is unpredictable whether a system blueprinted or redesigned after the German pattern, requiring expenditures of about eleven to fourteen billion dollars and annually, for instance, for a like American program, large numbers of government and state officials, strict bureaucratic control, and regimentation as a *conditio sine qua non*, will operate smoothly and efficiently in nations with completely different social economics, traditions, and ideologies.

Dr. SHEARON. I am moving around here and there a little, giving all these odds and ends, but I think it is rather important to do so.

There was read into the record the other day an editorial in the Journal of the American Medical Association for May 8, 1948, which made it appear that the National Health Assembly was a meeting in which sweetness and light prevailed, and there was a harmonious meeting ground of common thought, and everything went off beautifully. I stated at the time that I did not see it in that light, but that I had not seen it in that light from the beginning, and that there were other persons who thought about the total picture as I did, and regarded it as decidedly a political maneuver, and that the financing had come from the group that had an interest in enacting the Wagner-Murray-Dingell bill.

In this connection. I would like to introduce an editorial by Dr. Vincent Williams, this editorial appearing in the Jackson County Medical Society Weekly Bulletin, published at Kansas City, Mo., May 22, 1948, and it is an editorial on the National Health Assembly.

Senator DONNELL. It will be received and incorporated in the record.

(The paper referred to follows:)

EDITORIALLY SPEAKING—WHO SLANTS THE NEWS; IS "ALL QUIET ON THE POTOMAC"; OR DO LEOPARDS CHANGE THEIR SPOTS?

Last January, Mr. Donald Kingsley wrote a letter embodying ideas and philosophies dictated by his boss, Oscar Ewing, Federal Social Security Administrator. Guess who signed the letter but our own President Harry Truman. And to whom was the letter sent? To Mr. Oscar Ewing!

A few days after this fond, affectionate, round-robin exchange of correspondence, papers of incorporation were deposited with the District of Columbia Recorder of Deeds. Expressed in this document was explicit, even ostentatious, disavowal of any possible stigma concerning lobbying. The institution was called: The National Health Assembly, Inc.

Thus, after Mr. Ewing had ghost-written a letter for Harry Truman's signature (a not unusual practice in Washington, we understand) Ewing stood directed—by his own letter—to study health matters in our United States. To make sure no one could prove bias—for Mr. Ewing is admittedly and avowedly an exponent of state medicine—the above-mentioned clause was inserted in the articles of incorporation, providing a tailor-made answer to any allegation of "stacking the cards," in the then forthcoming National Health Assembly (which already had been blueprinted).

By this subterfuge and ruse everything on the surface was made to appear sacrosanct, clean-cut and above reproach; almost as pure as a certain laundry soap is advertised.

Moreover, since Federal statutes prohibit the use of government funds for lobbying purposes, this maneuver adroitly sidestepped any such criticism. Where did the money necessary to implement this program come from? As best we can ascertain, from the Lasker Foundation, the Milbank and Rosenwald funds. These sources never have failed the sponsors of compulsory state medicine, and as usual, they again produced, they forked over. In addition, other dollars trickled in from American Cancer, Infantile Paralysis, and the American Red Cross people. All this added up to a holy invocation in the proposed, and ostensibly righteous, crusade.

The Assembly opened with great éclat and fanfare. Our President personally charged the group with solemn responsibilities and duties. He again quoted discredited statistics (although he had been given the honest draft rejection figures in December of 1947, and moreover, he must have chosen to ignore the Brookings Institution data) thus deliberately "slanting the news," as a springboard for the ensuing seance.

After such an auspicious beginning—for devotees of compulsory plans—the remainder of the proceedings might be considered largely as window dressing; the juggling or balancing acts, if you will, leading up to the main show. Some say these were merely the build-up for the real performance in section 8. This section was labeled: Medical Care.

In this committee, practicing physicians had representation of sorts. Yet the final "steering" committee report is replete with double talk, nuances, implications and inferences which say everything and nothing—everything to the proponents of compulsory state medicine, and nothing to the average American physician, except specious sophistries and glib generalizations.

The sum total of this entire meeting was editoriailzed on May 8, in the Journal of the American Medical Association, with Morris Fishbein bestowing his blessings. Also, his telegram to Oscar Ewing stated, "Again, my sincere congratulations on the best meeting of its kind I have ever attended." This proffered olive branch already has been gleefully exhibited to prove that the official spokesman of American medicine was sold on the Assembly action. We hereby offer big odds that within a year somebody will be screaming, "We wuz robbed."

With this brotherly-love endorsement, do we see sinister, insidious shadows of Munich, of Tehran and of Yalta? Or, is the AMA using the recently adopted Molotov technique: Making this gesture to the do-gooders realizing that before long they will reveal their own true selfish motives, thereby reflecting credit on the medical profession for a sincere effort to cooperate, and thus foisting any opprobrium (in case of miscarriage) squarely on the bureaucrats? Does anyone believe that Oscar Ewing—who publicly has declared to the contrary—will feel compelled, in his final report to our President, to abide by the Assembly's decisions (which were left in a scrambled, half-baked form)? Does anyone deny

> the obvious and patent efforts to "slant the news," to stack the cards in this meeting, even if such schemes only partially succeeded? Does everyone feel that all is "quiet on the Potomac"? And finally, are we asked to believe that leopards change their spots?
>
> VINCENT WILLIAMS, M. D.

Dr. SHEARON. This article refers to an editorial in the Journal of the American Medical Association. This is a medical man speaking and referring not only to the editorial but also to the telegram which Dr. Fishbein sent to Oscar Ewing which states: "Again, my sincere congratulations on the best meeting of its kind I have ever attended," Dr. Williams says:

> This proffered olive branch already has been gleefully exhibited to prove that the official spokesman of American medicine was sold on the assembly action. We hereby offer big odds that within a year somebody will be screaming, "We wuz robbed!"

I do wish to indicate that the doctors of the country have not been too gullible in regard to that report of the assembly and the seeming great areas that everybody had in common.

I also wish to put in a statement, a letter put out by the Louisiana State Medical Society May 17, 1948. They had two of their representatives here, but did not get a delegate's pass. One of the representatives was Mr. Frank Lais, Jr., executive director, and Dr. Talbot, Dr. P. T. Talbot, secretary-treasurer of the Louisiana State Medical Society, and here is his statement. I do not think it is necessary to put it all in, but Dr. Talbot near the end of this letter refers to a statement by the Chicago Tribune at that time referring to the National Health Assembly as a "stacked seminar to promote the Truman program of state medicine."

When Mr. Falk testified in regard to what I have said about his volume "Medical Care Insurance," he used a considerable amount of strong language. I do not think I have the volume here, but that does not matter. He said that I had misrepresented this transcript to the committee, and that my statements were untrue, and that he had shown no bias, and so on and so forth. I certainly will not take your time to go all through this document page by page, but it is a very illuminating experience to do so, and since this has become sort of a bible on medical care insurance and the way in which a compulsory insurance program would operate, I should like to point out just a few of the things that were said. For instance, Mr. Falk stated that he gave an entirely unbiased view and did not point up one method of doing things any more than another, but Mr. Altmeyer in his original letter, which appears here at the beginning of this document, dated April 22, 1946, states:

> But it was necessary at some point to select what seemed to be the best alternative, since the analysis of other problems was dependent upon such selection.

In other words, Mr. Altmeyer himself in his covering letter states that they did make the selections that they thought were best. Other people might not think they were the best selections. The document was prepared by Mr. Falk. It says so here in the beginning of the report. Mr. Altmeyer says that himself.

Now, I point out that all the way through the document there is a bias toward the capitation or salary method of payment. That has been Mr. Falk's point of view these many years. There is nothing new in that, so I don't see why he should deny that he had a bias.

He believed that that was the best way to do the thing. In other words, that you cannot have the fee-for-service basis of payment if the Government is going to take over the job. That has been demonstrated over and over again. It is well known regarding administration of compulsory health insurance. It has been Mr. Falk's view for a long time. I refer here to an article which he published in 1944 on the proposed extension of the social security program, with special reference to health and medical aspects. This was published in the New England Journal of Medicine, volume 230, pages 243 to 249, March 2, 1944. And he says here in referring to the methods of payment:

> There is little doubt that some of the most serious deficiencies of present-day medical practice result from the fee-for-service method of payment.

And after a lapse he goes on to say also:

> Practitioners here, like those in Great Britain, would probably turn to capitation or a salary basis of payment, because they have learned by experience that these methods are more satisfactory for them as well as for their patients.

This has been his point of view for a long time, so why he should deny that it was his point of view or that he held it up time and again throughout this report as being the favored method of doing things, I cannot understand.

You yourself, without having looked at the book before, pointed out several places where he did that. I have gone through the book and could make a list for you of the places all the way through the book, where he underlines the capitation method as the method of payment, the favored method, either capitation or salary, that he would approve, always playing it up as the method most simple for the Government and for the doctors and therefore the patients, and the fee-for-service method is cried down as being unsatisfactory, as being wasteful and expensive. In the chapter on costs, all the way through he refers to per capita cost. In chapter 15, one place after another, in the table summary, he alludes to per capita costs, summarized in table 13. And on page 149 per capita costs are shown, table 14, "Per capita costs. Costs of health insurance funds." He goes on to say that in a summary table on page 185, where he gives a summary of the costs of the health insurance benefits. The whole table is based on per capita costs, on the assumption that the entire population of 140,000,000 persons will all be brought in, and that therefore you can say the Government will spend so much per year for physicians' services, so much for hospitals, so much for dentists, per capita, and you add up those several per capitas and you have the total cost of the program.

He objected to my saying that he was planning on a 5, 10, 15-year basis. He does not say "planning." He says initial per capita and total cost for the early years and for 5, 10, or 15 years later. That is on page 185. He refers to that long-time planning in a number of places throughout the document. He refers even to the method by which they would pay groups of physicians if they chose to organize in groups, 25 or 30 physicians, or into a group at a hospital. He has this to say on page 133, beginning at the bottom of page 132:

> The staff physicians of the group will probably, therefore, prefer that the group be paid on a capitation basis. Not only physicians on the outside, practicing in solo practice, but also if they practice in a group, they would prefer

to be paid on a capitation basis and not be subject to prorating controls that may accompany fee-for-service payments. Also, if the group remuneration from the insurance system is on the per capita rather than on the fee-for-service basis, a large amount of paper work is avoided.

Discussing the amount of work involved, if you pay on a fee-for-service basis, you eliminate that, he says—

if you resort to the capitation method.

"Consequently," he goes on, "even though individual practitioners may choose the fee-for-service, the group could still use the capitation or other methods of payment."

That goes on for line after line, and so, as I say, it is absurd for him to deny that that was the method that he favored, and that is favored by all persons, I think, who are working in the field, who would say that of course if the government is going to do the job, you cannot go through the amount of administrative work entailed by paying for individual claims by individual doctors. You can see for yourself what that would involve, therefore you must do it in some organized fashion. The reason for calling for organization of medicine under an insurance system is that with a capitation system you get away from some of this paper work. That is, of course, if you do not say anything about the new and additional paper work, which would be far in excess of anything that one might have in the way of paper work if individual doctors would engage in private practice.

There is so much that could be said on this, but I do not want to take the time of the committee now. The scheme is presented in a way, though, to sell something to Congress and to the public. The statements that they make in regard to the cost of the program are absolutely absurd. They determine that in advance—"we are going to make it come out around 4 percent, so it will not be too big for the whole program." Then they proceed to argue from that figure, 4 percent, because that has always been the cost claimed by anyone working in the field. But they know it would cost a great deal more than that. The main thing in the planners' minds has been to get the program started, to keep information about costs away from labor and away from Congress, so that labor would think it was going to get something for nothing, and after they got it started it could not be stopped.

I would like to ask permission to insert, at a later time, a statement in regard to Father Schwitalla at this point, in view of the fact that an insert was made by Senator Murray some time back that would indicate that the Catholics were in favor of compulsory sickness insurance. I think this is due to Father Schwitalla, who is very ill at the present time, at death's door. He has expressed his views before this committee, and I have some additional material which I was not able to get ready, but would like to submit to you, and you can look it over and decide whether you will insert it.

Senator DONNELL. When do you think you will have it ready?

Dr. SHEARON. You may recall that when Mr. Falk was testifying he said categorically——

Senator DONNELL. Pardon me, I don't know whether you heard, but I asked you how soon do you think you would have that statement by Father Schwitalla ready?

Dr. SHEARON. I have the material ready on my desk but just did not have time to present it. I think I could get it ready in a day or two.

Senator DONNELL. Within a week anyway?

Dr. SHEARON. Within a week's time, yes.

Senator DONNELL. Very well, we will receive it with the understanding that it will be within a week from the present time.

Dr. SHEARON. I would like to give one other illustration. The statement was made by Mr. Falk with regard to his national and international activities. He made a categorical denial, as you will probaby recall, that he was working for compulsory insurance on the international level. Now, I submit that he has been so working for years; that he has worked for the International Labor Organization and with the Inter-American Committee to promote social security, with the Montreal office of the International Labor Office, and that he has very definite views on world planning. I wish to quote just one of his views to indicate what I have in mind. I am referring here to document S. S. C., No. 4, from the International Labor Office, being a record of a meeting held in Montreal, July 9, 10, 11, and 12, 1943, on social security. It was a social security consultation on income maintenance and medical care, and on page 154 of that report—and I might say that Mr. Falk took an active part throughout these discussions, and the discussions related to the ways in which you could set up medical care plans throughout the world, how you would draft legislation, how you would administer the plan—he says that he would prefer this wording of the text. They are discussing a text which they are prepared to put out, maybe did put out. This is in the discussion when he and Mr. Perrott and Mr. Wilbur Cohen and Mr. Altmeyer were all there, and he says——

Senator DONNELL. This is what Mr. Falk says?

Dr. SHEARON. Mr. Falk says:

> Indications for medical care through public services.

He means by that, services paid from general revenues, not under an insurance scheme—in other words, services like education, supported by the entire population.

> Such services may be preferred, especially as an ultimate objective, in the light of experience accumulated under contributory social insurance.

That is the point I have made over and over again, namely, that they have in mind as an ultimate objective that you will come to a complete national medical service, a salaried service, such as they have in Russia; that that shall be the ultimate objective. He states that very clearly. Then he goes on to give his reasons, and they are good reasons. They are reasons that I had when I was studying it, that if the Government is going to provide medical care for everybody, the way to do it is to do it from general revenues and not under a social security system with special taxes and with all sorts of exclusions, very difficult to administer.

Senator DONNELL. You used the word "salary" a moment ago, that you said prevailed in Russia.

Dr. SHEARON. Yes.

Senator DONNELL. Just what did you mean by that? Was that in connection with your earlier comments about his advocacy of the capitation plan?

Dr. SHEARON. Yes. As I have said over and over, he advocates capitation or the salaried method, but you come to the capitation first.

Senator DONNELL. And salary afterwards?

Dr. Shearon. You come to the salary ultimately. Going back a little bit he says:

> Such services—

that is, public services—

> may be preferred, especially as an ultimate objective, because all prospective beneficiaries have the same type of benefits.

In other words, everybody will be treated just alike and he would not have any exclusions, would not have any check on whether or not patients were in the insurance system or whether they were entitled to benefits. Everybody would be entitled to benefits by virtue of being a member of the community.

The second reason he gives for that ultimate objective is that physician's services for essential needs should not depend upon any qualifying conditions. In other words, you should not relate the medical benefits you give to any such qualifying condition as whether or not a person is employed or has paid his insurance premiums or not, the idea being that if, as a member of the community, he is entitled to these services from general revenues, then there would be no qualifying conditions. He would just walk into the doctor's office or enter the public clinic, be treated, and, would not pay for services at the time.

A third reason why he takes general services as an ultimate objective is that when it is decided to integrate medical care services with other health services it will be easier if all are universal and are paid from general revenues. In other words, they are thinking that ultimately all these preventive and curative services would be merged into a single service that would be handled by the Public Health Service or the Public Health Department, or perhaps some new department that would be set up; that you would merge all present public health services in preventive medicine, things that are done for large populations, such as inoculations, malaria and typhoid control, and that sort of thing—with the medical care for individuals.

So he says that it would be desirable to take over the entire health and medical service for the whole population; that they would find justification for this over-all noninsurance program.

Then he goes on to say that in the case of public medical care as opposed to social insurance services, the latter may be preferred where the services are limited to a section of the population or to a specified area. That is a very peculiar thing for Mr. Falk to say, because he is advocating insurance for the entire population, with the argument that it ought to come out of general revenues, not out of a special, earmarked tax, yet he says the only real excuse you would have for establishing an insurance system would be the necessity of excluding part of the population, the noninsured population. In that case you would set up contributory insurance rather than pay for it out of general revenues. Then he turns around and says here that he would recommend social insurance services when the scheme is to be limited to part of the population, but on the other hand he is recommending all the time that we set up a social security contributory system for the whole population. So he is entirely illogical in his argument—if I make my point clear. In other words, he is working for the Wagner-Murray-Dingell bill involving social insurance techniques, and simultaneously advocating general taxation for medical care for the entire population. In his own statement here in the beginning you would think he was in favor of having medical care for everyone financed from general revenues; yet he also says he wishes to have it done through the social insurance system. However, there would be no social insurance system at all, if financing is from general revenues. If it is done for everybody, you would not have all these administrative difficulties, determining those who are entitled to care and those who are not entitled.

Then he goes on to say that you are justified in asking to have the program under social insurance when wholly or principally financed by contributions, with or without partial financing from general tax funds, and where the contribution mechanism already exists for other classes of social insurance. I realize that that is probably not going to sink in when the hearings are read. It is something that has to be studied, but the point I wish to make is that here is Mr. Falk in a methods, stating what his ultimate objective would be and how he would word the ultimate objective, and so on, showing that his categoric denial that he has been working on world plans was not correct.

Now I will go to the legislative history of the Wagner-Murray-Dingell bill. I will try to make it as brief as possible, but you ought to have it all together in one place.

There were private groups, as we have seen, working on the early studies for nationalization of medicine 20 years ago. They called it "socialization." They were thinking at that time primarily of having it done at the State level, although I think some persons were probably thinking of it at the Federal level. But that was the talk in those days, getting through a compulsory insurance law in some of the States. Bills were introduced, studies were made, and there was considerable activity. The Committee on the Costs of Medical Care came through with quite mild proposals. They favored pursuing voluntary methods further before resorting to compulsion. They felt that compulsion would be bad.

In 1933 Mr. Falk left the Committee on the Cost of Medical Care and went to the Milbank Fund, where he was associated at a later time with Mr. Sydenstricker, who was a statistician from the Public Health Service, loaned to the Milbank Fund. He worked there in collaboration with Harry Hopkins. Harry Hopkins, of course, was not with the Milbank Fund, but they had meetings together. They were trying to decide how to put this program over, and on March 15, 1934, Harry Hopkins said:

> You are not going to get health insurance if you expect people to do it voluntarily. I am convinced that by one bold stroke we could carry the American people along, not only for health insurance but also for unemployment insurance. I think it could be done in the next 18 months.

At that time Mr. Falk was working with the American Association for Labor Legislation. They were strongly in favor of compulsory sickness insurance, and wanted to have legislation passed. He and Mr. Altmeyer and Wilbur Cohen for years have been publishing articles in the American Labor Legislation Review, and in 1936 Mr. Falk was elected to one of their boards.

I have also pointed out that in 1934 the United States joined the International Labor Organization which was dominated for 15 years by the French Socialist, Albert Thomas.

So I want you to see that this movement has been progressing on a number of different fronts. You had the Milbank Memorial Fund working steadily toward this type of legislation, you had labor organizations like the American Association for Labor Legislation, you had the International Labor Organization, which we joined in the spring of 1934. That was very hurriedly done. There was no adequate consideration given by Congress. It was done at the instance of Secretary Frances Perkins. She got the approval of President Roosevelt. She sold the idea to the House—and I might say that some of her testimony was not entirely accurate. I think the House was not well informed, in that the bill was rushed through as many bills are rushed through at the end of the session. It was approved on June 16, 1934, and authorized our joining the International Labor Organization. President Roosevelt immediately took steps to accept such membership for the United States. He then straightway set up the Committee on Social Security—no, the Committee on Economic Security. That committee consisted of Frances Perkins, then Secretary of Labor, who was chairman; Henry Morgenthau, Jr., Secretary of the Treasury; Homer Cummings, Attorney General; Henry A. Wallace, Secretary of Agriculture, and Harry L. Hopkins, Federal Emergency Relief Administrator. That committee immediately started, first through studies, to prepare for legislation. They set up study groups, a large number of them, including groups dealing with health and medical matters and public health, together with the social-security program.

Frances Perkins states that she brought over two consultants from the ILO, Andre F. Tixier and Oswald Stein as consultants, and they helped in drafting our Social Security Act. She makes the boast in her book, The Roosevelt I Knew, which was published in New York in 1946, pages 339 to 346, also page 282.

These groups got together a number of reports for Congress, and finally put them together in one over-all group report to the President's Committee on Economic Security, published in 1935 and transmitted by this committee of five persons, to the President on January 15, 1935. It dealt primarily with old age and unemployment.

The report that was prepared on compulsory health insurance did not get very far, and the recommendations in the main dealt with the additions to public health services, possibly some grants-in-aid, extensions of the grants-in-aid program.

Following this report there was introduced in Congress just 2 days later, January 17, 1935, a rather large bill, 63 printed pages, known as the Economic Security bill. And I would like to point to the peculiar coincidence that has been repeated over and over again in the years since that time, where a big report goes to the President recommending certain things, and on the same day or a day or two later a full-blown bill is introduced into Congress embodying all the recommendations, showing that the two things were coming through simultaneously and were prepared, shall we say, by some committee or some group in the Government.

I wish to refer to one thing in that original bill. There was a section, No. 402, in Senator Wagner's bill, S. 1130, of 1935. That was the original draft of the Economic Security bill, and the companion bill was introduced by Representative Doughton of North Carolina. That section 402 relates to the duties of the Social Insurance Board, as it was called in that original bill, and states, among other things, that it shall have the duty of studying health insurance. There was no health insurance title in the original bill, so the subject was put into the duties of the Board. And I might say that President Roosevelt vetoed the suggestion that there be included in that original bill a compulsory health insurance title. He did not think the people were ready for it, that it was too controversial and might keep the rest of the bill from getting through. That is my surmise from what I have read.

That statement of the duties of the Social Insurance Board, including health insurance, aroused a great deal of unfavorable comment, and eventually Congressman Doughton introduced a new bill, H. R. 7260, April 4, 1935, which was the bill that eventually came through and was enacted and became the Social Security Act.

In that new bill there was section 702, relating to the duties of the so-called "Social Security Board"—the way the bill finally came through, instead of "Social Insurance Board"—and there was omitted from those duties, the duty to study health insurance. I think it is extremely significant that Congress considered whether or not they wanted the Social Security Board to study health insurance, and then decided that they did not want the Social Security Board to do that, and they left it out.

As section 702 came through—and it is an extremely important section on the duties of the Social Security Board—it says:

> The duties of the Administrator—

as it originally came through it was "duties of the Social Security Board"—

> The Administrator shall perform the duties imposed upon him by this act, and shall also have the duty of studying and making recommendations as to the most effective method of providing economic security through social insurance, and as to legislation and matters of administrative policy concerning old age pension, unemployment compensation, accident compensation, and related subjects.

The unfortunate three words in that section are the last three, "and related subjects." The best recommendation I could make to this committee would be to amend the Social Security Act and change that umbrella-like term "related subjects," because it simply means that the Board can do anything that it feels like and can get around the original intent of Congress to prevent their studying health insurance. And they have cited this section over and over. I think there is not a time when they put out an annual report, or any report on why they are studying health insurance, that they do not refer to this section, almost as though they had a guilty conscience in the matter, and that they have to say, "We are doing it because of this section. We are well within the law." Nobody is questioning them, and I don't know why they refer again and again to the original law, saying, "We have a perfect right to do this. Section 702 says we may." Under that section, in the light of the history of the bill, I think it could be denied that they have ever had a right to study compulsory health insurance, to initiate legislation to extend their efforts out all over the world, specifying how that insurance shall be legislated and how it shall be operated. I think that is an extremely important section.

Now, the bill as passed, the original Social Security Act, enacted August 14, 1935, does not contain anything about compulsory health insurance. It related to old-age insurance, unemployment insurance, and the assistance programs in aid of the needy aged, and the blind, and dependent children. It also has two titles relating to services to be conducted by the Children's Bureau.

Senator DONNELL. Doctor, what is your best estimate as to the time you will require—not intending to hurry you at all?

Dr. SHEARON. I think it will take me about 2 hours. I might finish in an hour.

Senator DONNELL. We will recess until 1:30 this afternoon.

(Whereupon, at 12:55 p. m., the subcommittee recessed until 1:30 p. m.)

AFTER RECESS

Senator DONNELL. The committee will be in session.

Dr. Shearon, will you proceed?

Dr. SHEARON. I have been speaking about 1935, the enactment of the Social Security Act. The Board was immediately set up and the first persons in the Social Security Board, administratively, were John G. Winant, who was made the chairman of the Board, a three-man board. I believe that he was brought in from the ILO. He later went to the ILO as a director, but I think he had been brought in from the ILO.

In other words, he was closely connected with the ILO. Arthur J. Altmeyer was the second member of the three-man board, and Walton H. Hamilton, who was a professor of law, became the first director of the Bureau of Research and Statistics. Mr. Falk came into the Board on December 1, 1936, and other persons who had been connected with him on the Committee on the Costs of Medical Care were Louis S. Reed, Margaret C. Klem, and Martha D. Ring, whom I mentioned this morning. All came into the staff of the Social Security Board early, and eventually came into Mr. Falk's own staff even if they did not come in with him in the beginning.

Now, he came in, in a very minor position in the Bureau of Research and Statistics, but after a little time he created a Division of Health Studies, which has been the propaganda nucleus in that Bureau of Research and Statistics ever since; that is, it has been a nucleus around which certain activities have been developed in connection with the promotion of a national health insurance scheme.

Mr. Falk did not have much money or much staff in the beginning, but the persons who were ahead of him administratively left or were moved elsewhere and finally he became the director of the Bureau of Research and Statistics on September 15, 1940, at a salary of $8,000. His staff jumped overnight to 186 persons and the appropriation that was available to him jumped to nearly half a million dollars. With the help of this money and the staff he was then able to undertake the drafting of national legislation.

In 1938 a National Health Conference was called by President Roosevelt and Mr. Falk's staff was extremely busy preparing material directed toward showing the need for Federal governmental intervention in the health field.

That meeting of the National Health Conference in 1938 was decidedly a biased meeting designed primarily to put over a Federal health program. They brought out a large number of recommendations, and in the year following that National Health Conference, the staff of Mr. Falk was engaged in writing the first Wagner health bill.

It is significant that the technical committee on medical care at that time comprised Dr. Martha Eliot of the Children's Bureau, I. S. Falk of the Social Security Board, Joseph W. Mountin of the Public Health Service, George St. J. Perrott of the Public Health Service, and a Dr. Clifford E. Waller of the Public Health Service.

This group has worked together these many years in the Federal Government to develop this national program. I think it is important to bring out that the reports and recommendations in many instances were initiated in the Bureau of Research and Statistics.

It was not that Congress asked for help and guidance and reports, but rather that in the Bureau we initiated them. I worked for 2 months on the medical care provisions of the first Wagner bill, the bill of 1939, S. 1620, which was eventually introduced on February 28, 1939, and which called for grants-in-aid for medical care and for other purposes.

In passing, I might say, there seems to have been some misunderstanding about my own reactions towards that bill. I might say that at that period of my own studies I had not been in the field very long. I did not even want to be in the field, but Mr. Falk said I would have to devote my full time or nearly my full time to health matters.

My interest was in the field of old-age insurance. Mr. Falk said that the old-age insurance field was to be played down and the health insurance field played up. That was to be the next big thing in social security, so that I, in joining his staff in 1937, found myself in this health field in which I was not interested.

However, since I was asked to work on it, I made a very careful study of it, especially the administration and programs in other countries, and as I say, I worked on this bill which eventually became S. 1620 of the Seventy-sixth Congress, first session.

I was asked to implement one of the recommendations of the National Health Conference, namely, to develop a bill for medical care for low-income groups, and that was the type of bill that I did develop.

I might say that the bill, as I drafted it, left my hands some 2 months before it was introduced. I never saw it again, I never heard anything about it. When the bill was finally introduced by Mr. Wagner it had many very unsatisfactory provisions from the point of view of the technical staff.

We were all greatly disillusioned. It was our first experience with drafting Federal legislation, and when we saw the bill as it came through we felt that it was undesirable. I think most of us wished that it would not be enacted, and in time it died in committee, and we were very grateful for that.

Now, that was in 1939. By 1940 Mr. Falk had become the Director of the Bureau and was in a position to take a much stronger position than he had on the early bill. Unfortunately, from his point of view, we were brought into the war in December 1941, and governmental activities were directed towards the winning of the war.

A good many persons devoted their time to the winning of the war, but it is a noticeable thing that 5 persons succeeded in keeping out of the fighting, and in doing a lot of things that were not necessarily for the good of the United States or of the Federal Government.

I mentioned those five. One was Howard M. Klein, who became the executive secretary of the National Health Assembly which was held this year, May 1 to 4, 1948. He obtained a so-called essential job in the United States Public Health Service.

William G. Reidy was another who did not get into the war. Wilbur J. Cohen kept just one step ahead of selective service in a so-called essential job in the Social Security Board, and Milton I. Roemer found himself an essential job in the Department of Agriculture, as did Fred D. Mott.

These persons did not fight for their country, but they did work on the movement for the nationalization of medicine.

During 1942 and early in 1943 Mr. Falk's staff was extremely busy in developing a bill which was later introduced by Senator Wagner for himself and Senator Murray. It was introduced on June 3, 1943. That bill was S. 1611 of the Seventy-eighth Congress, first session.

That bill has been called the blueprint for the nationalization of medicine because it contains the over-all provisions for a broad social-security program which would include all these old-age benefits that we have spoken of, the cash disability benefits for sickness and for permanent disability, extended public-health services, services for children, and then this whole medical-care insurance.

I was not on Mr. Falk's staff at that time. I had left in 1940 and had gone over to Dr. Parran's staff in the Public Health Service.

I think the way in which that bill was written is significant. We have been told that these bills have been initiated at the request of Congress. During 1942, late in 1942 and early in 1943 there were two bills being written by Mr. Falk's staff that caused a great deal of confusion and misunderstanding. People did not know why there should be two bills which would embody the recommendations of the Social Security Board to Congress. It finally reached the stage where there were two pretty well formed bills. One was being called the A. F. of L. bill and the other was called by the people in the Social Security Board "our bill". In other words, it was the Social Security bill.

Mr. Altmeyer sent a letter to Dr. Parran early in 1943 asking him to have luncheon with him to discuss the recommendations that were to be made by the Social Security Board in this field. It was a very hurried affair.

The letter arrived on a Friday and Mr. Altmeyer wanted to see Dr. Parran the next noon for luncheon.

I was hurriedly called out to Bethesda on Friday to look over the letter together with certain portions of a bill that purported to be the bill which would be introduced sometime in the rather distant future, and when I looked at it I said, "Well, my recommendation to Dr. Parran would be not to have anything to do with this bill. If he does he will be damned as the czar of medicine."

I said, "Furthermore, there is something very peculiar about this. We are being shown certain sections of a large omnibus bill but we do not see the whole thing. We do not see how the administration is to be set up, how the funds are to be collected, how the funds are to be distributed, and so on. We do not see any of the financing or any of the administration."

I said, "It is a very curious thing. We should have a great deal more information, and I would recommend that the Surgeon General go very cautiously in anything that he does."

He went to his luncheon the next day with Mr. Altmeyer and he made certain very definite recommendations and asked to see more of this so-called Social Security bill. It was "our bill," it was what "we" were going to recommend, i. e., the Social Security bill "we," the Social Security officials, were going to recommend.

The Public Health Service never succeeded in obtaining the remaining parts of that bill. It was a very peculiar thing that an important piece of legislation like this was bing drafted in the Social Security Board by a group of nonmedical people. They had no dentists; they had no nurses. They had one doctor of medicine. That was Dr. Ruth Stocking. Here was this important piece of legislation which presumably the Surgeon General would administer, and yet it was drafted in the Social Security Board, and the Public Health Service was not consulted except at these one or two perfunctory luncheons that Mr. Altmeyer had with Dr. Parran.

Well, now, at that time there was this second bill. The peculiar thing there was that this second bill was going through at the same time. It was called the A. F. of L. bill. Well, I finally, as the spring wore on in 1943, conferred with a member of Mr. Falk's staff to see what was the relationship between these two bills, and I found that they had certain provisions in common but certain provisions were quite different, and the curious thing was that there were a great many provisions in the bill that was being shown to the Public Health Service that were very favorable to the Public Health Service, in other words, designed to bring them along and to induce them to give their support. The provisions, seemingly, were designed to make the Public Health Service say, "Well, this is a good bill." But those provisions were not in the A. F. of L. bill, and the staff down at the Social Security was greatly mystified. They did not know why there should be two bills in circulation being developed simultaneously.

On March 17, 1943, Mr. Altmeyer wrote to the Surgeon General enclosing a draft, a rough draft, of the bill of March 8, 1943, saying, "I am sending you a rough draft of a bill which we have drafted"—the Social Security people—"in connection with the health section of the recommendations we will probably make to Congress."

There is no indication that anyone in Congress had asked them for anything.

> This is in very rough shape even without the benefit of legal advice, but I thought it would be helpful if you and I could discuss some of the important policy questions involved before we had our respective technicians undertake to put the language in more exact form.

On May 25 Mr. Altmeyer wrote again to the Surgeon General. That letter was received on May 31 or June 1 of 1943. The Surgeon General was out of the city at the time. He was down in Virginia attending a nutrition conference, but the letter said, and I quote Mr. Altmeyer's words—

> This revised draft is still in very rough shape and has not been revised by the lawyers. However, I thought it best to send you the draft in its present form, so that our respective technicians may now begin to spell out the language and the policy for our further consideration.

That was received, as I say, on May 31, or June 1, 1943.

People I knew down in Social Security called me up and laughed, saying, "Well, what is the matter with you people out in the Public Health Service? There is a big omnibus bill coming through in Congress. It's about to be introduced by Senator Wagner. We have already written the news releases for it here in the Social Security Board. The releases have been out for a week or 10 days. It is quite likely that the bill already has a number on it or is very close to the number stage in Congress."

I said, "Why, that is impossible. We have just received a letter from Mr. Altmeyer saying that the bill is far from being ready; that it has not been revised by the lawyers and still is in very rough shape."

Two days after that, S. 1161, full blown, was introduced by Senator Wagner for himself and Senator Murray.

Well, I was immediately asked to analyze it for the Surgeon General and to prepare a statement that he could send to Mr. Leonard J. Calhoun of the general counsel's office of the Federal Security Agency. I prepared an analysis for Dr. Parran, and I prepared a letter for him to send to Mr. Calhoun.

That letter is dated July 2, 1943. I was so familiar with the point of view of the Surgeon General that when he read it he made only one slight change in one sentence and accepted the rest in toto, signed it, and sent it on as being his views.

I think it might be helpful in view of the subsequent events to have a copy of that letter inserted in the record showing what the Surgeon General thought, because a great many untrue things were subsequently said about him and have been said about him up to the present time. He has lost his position as Surgeon General because of untrue things that have been circulated about him, and in the interests of an honest history of what happened at that time I would like to submit this copy.

Senator DONNELL. It will be received in the record and included in full.

(The memorandum referred to is as follows:)

JULY 2, 1943.

MEMORANDUM

To: Mr. Leonard J. Calhoun.
From: Thomas Parran, Surgeon General.
Subject: Wagner bill, S. 1161, To provide for the general welfare; * * * to establish a Federal system of medical and hospitalization benefits * * *

In commenting on this bill, I should prefer at this time not to commit myself to accepting or rejecting it, but rather to indicate some of the controversial issues involved and some of the more important issues at stake.

Since the question of health legislation has been raised by the introduction of this bill, I should like to point out that the several divisions of the Public Health Service have for some time been engaged on surveys of the health needs of the country and on recommendations as to ways in which these needs may be met. Studies have been made of health programs in other countries and of current proposals for the reorganization of health and medical programs in Canada, Great Britain, New Zealand, and elsewhere. These studies and surveys are now approaching a stage where we would be justified in seeking the advice and cooperation of medical and other professional groups regarding postwar plans for a comprehensive health program in this country. From such deliberations and from the consideration of alternative methods for implementing a health program, there should emerge recommendations for action which might, after clearance with the Agency, be transmitted to Congress for appropriate legislative action.

Turning now to S. 1161, I shall make a few general statements and shall append a more detailed analysis which points out some of the implications of the bill.

1. As a matter of social policy, the question may be raised whether a compulsory health (or sickness) insurance scheme is the best method for improving the health of the people. I believe other plans should be explored and the advantages and disadvantages of the several methods freely discussed.

2. I believe we would do much to promote good will and to obtain the cooperation of the medical profession if we were to refrain from any effort to crystallize postwar patterns of medical practice until (a) there has been a sincere and forthright effort to elicit constructive suggestions from outstanding leaders in the medical profession, and (b) the physicians now serving in the armed forces have had an opportunity to express themselves regarding plans which will greatly affect their professional futures. We should avoid giving the medical profession any reason to think that an attempt is being made to rush through health legislation while one-third of their number is preoccupied with the pressing duties of war service and the other two-thirds are busy with the responsibilities for civilian care.

3. I believe the health program of this country is important enough and sufficiently specialized to warrant having its administration separate from the social-security program. It would be both feasible and desirable to place full administrative responsibility in the Public Health Service. Sharing of such responsibility with the Social Security Board would appear to have many disadvantages. After long years of experience in Great Britain it has been advocated that the health and medical programs be separated financially and administratively from the income-maintenance programs, the former being placed under the jurisdiction of the health agencies, the latter under the jurisdiction of the social-security insurance agencies.

4. Unless all our health activities, preventive and curative, are closely integrated into a single health program there is danger that overemphasis on sickness will make us lose sight of the fact that primary emphasis should be on prevention. If huge sums of public tax funds are to be poured into a far-reaching medical care program, it is likely to become difficult to obtain added funds for the program of prevention and to put off the day when prevention and cure will be merged. If billions of tax funds are to be spent for medical care as against millions for prevention, there will be little improvement in national health.

5. It would be difficult, if not impossible, in many instances to carry out the provisions of the Wagner bill because it promises facilities and services that were not available before the war, are not now available, and cannot be made available for some years after the war. Hospitals, health centers, and clinics would have to be built, but there is no provision in the bill for such increase of facilities. People in rural areas have not in the past had access to adequate health services and facilities. Obviously for some years to come it will be impossible to give to rural populations the services and facilities promised to them in the bill. Under this legislation the Government would enter into a contractual relation (legal or moral) with insured persons to give certain services beyond its power to give. Labor would be disappointed, the Government discredited. We might properly be accused of promising to give to the public something that could not be delivered and the bona fides of all concerned with the implementation of this legislation might be questioned. I do not mean in any way to question the good faith of Senator Wagner in proposing the bill, but rather to point out that he was apparently not fully informed about the health needs of the country, the current inadequacy of facilities, the shortage of medical personnel, and the length of time required to put our medical house in order.

6. The launching of an adequate, purposeful health program calls for concerted action on many fronts. The program must be constructively built, section by section, on a firm foundation of wide-spread health education in home, school, factory, and mine. People must be made to appreciate and ardently desire health or they will not seek, or greatly benefit by, the services offered. This job of education cannot be done overnight. Time must be allowed to train personnel and to take the message of health to all the people. Doctors must be induced to establish themselves in rural areas and they cannot be so induced if there are no facilities to attract them.

7. The provisions of the bill appear to be inadequate in many respects. There is no provision for (a) care of the tuberculous and for those suffering from nervous and mental disorders, (b) care of various excluded groups, (c) construction of facilities without which the program could not be launched, and (d) dental and nursing service, except as these may be furnished at some later date.

8. I believe the time is inauspicious for the passage now of health legislation and that we should study and plan for immediate postwar action without making binding commitments now on all details.

9. I think it would be unwise to initiate a comprehensive health program with a sum running into the billions the first year and that it would be wiser to work out a 5- or 10-year plan with appropriations increasing each year as the program was put into operation on more fronts.

10. We should explore the possibility of expanding the present title VI of the Social Security Act.

All these matters will be discussed more fully by technicians on my staff in their forthcoming reports, and I should therefore prefer not to go into the subject further at this time.

Dr. SHEARON. Now, in addition to that I might say that we in the Public Health Service did not see this bill until after it was printed. This is S. 1161 introduced by Senator Wagner on June 3, 1943.

(At this point Dr. Shearon submitted the following memorandum:)

Shortly after the Wagner-Murray-Dingell bill was introduced—June 1943, Kenneth C. Crain, vice president, eastern editor of Hospital Management, wrote to Dr. Parran for a statement on the bill. I prepared the reply for Dr. Parran's signature. The letter, dated July 17, 1943, follows:

FEDERAL SECURITY AGENCY

UNITED STATES PUBLIC HEALTH SERVICE, WASHINGTON

BETHESDA (14) STATION, *July 17, 1943.*

Mr. KENNETH C. CRAIN,
Vice president-Eastern Editor, Hospital Management,
330 West Forty-second Stret, New York, N. Y.

DEAR MR. CRAIN: This will acknowledge your letter of June 28 in which you ask for information about the plans of the Public Health Service for a medical care and hospitalization program to be developed along the lines proposed in the Wagner-Murray-Dingell bill.

At the time Senator Wagner introduced the bill he stated the legislation was sponsored by the American Federation of Labor. Whatever its origin, it is not an administration bill, and I did not see it before it was introduced. The Public Health Service has as yet developed no plans for a comprehensive medical care of hospitalization program. Indeed, implementation of the provisions of the bill at this time would appear to be difficult if not impossible in the face of existing and increasing shortages of medical personnel and of materials for the construction of additional health facilities.

As you can readily appreciate, my immediate concern is with urgent health needs in communities affected by the war either directly or indirectly. Considerable difficulty has been encountered in constructing even the few hospitals and hospital additions which are absolutely essential to serve the increased population in war-industry and extra-cantonment areas. The withdrawal of physicians from communities which never did have adequate medical services has created another problem, as has the shortage of nurses.

Thus our efforts for the present must be directed mainly toward emergency activities dictated by the war. Yet we cannot shut our eyes to the long-time health needs of the country nor can we wait until the war is over before considering ways in which the needs should be met. Proposals for national health programs are being advanced in several countries, notably Great Britain, Canada, Australia, and New Zealand. In this country, too, there is a revival of interest in some form of concerted action to bring about a more equitable distribution of health services and facilities after the war.

If and when a new health program is developed in this country, I think it will come as a result of free and open discussion of principles, objectives, and methods of implementation. The subject is highly controversial, as you have indicated, yet I believe we could avoid much of the bitterness that has delayed progress in other countries and has set at cross purposes those who should be working for the common good.

Personally, I have no cut-and-dried plans about the pattern to be followed in developing a comprehensive program, assuming one to be feasible financially and administratively in the near future. I think we would all agree that health services should be available to everyone and that Government has a responsibility for the health of the people. I believe, too, that much greater emphasis should be placed on preventive medicine in community heatlh activities and in the care of individuals and that present artificial barriers between prevention and cure should be broken down, not strengthened. At this time I do not see how we can go much beyond these general statements, for further discussion will be necessary before any commitments can be made. In approaching this whole broad problem there will be need for mutual trust and cooperation, freely given by public and private agencies alike, by professional and lay organizations, and by all groups and persons sincerely devoted to the advancement of health.

I greatly appreciate the interest you have shown in the work of the United States Public Health Service.

Sincerely yours,

THOMAS PARRAN, *Surgeon General.*

On July 22, 1943, Mr. Crain wrote to Dr. Parran as follows:

JULY 22, 1943.

THOMAS A. PARRAN, M. D.,
Surgeon General, United States Public Health Service,
Bethesda Station, Washington, D. C.

MY DEAR DR. PARRAN: Your thoughtful and far-sighted letter of July 17 contains so much of real wisdom and uncontroversial material in general on the subject of governmental assistance and initiative in the matter of public health measures that I trust we have your permission to publish it in full, exactly as written, in our forthcoming August number.

Meanwhile please allow me to say that it is impossible to quarrel with so reasonable an approach to these great problems as yours, and that your attitude will unquestionably go far toward making possible that objective inquiry into the infinitely varied matters involved which, as you point out, is essential before legislation can be seriously considered.

With personal regards, I am,

Sincerely,

KENNETH C. CRAIN,
Vice President—Eastern Editor.

This letter was referred to George St. J. Perrott, who insisted that if the Parran letter was printed the second sentence in the second paragraph should be omitted. I protested that we all knew Dr. Parran had not been consulted. Mr. Perrott admitted the fact, but said a pointed statement to that effect should not go out. (Perrott has always been responsive to Fall's wishes. He explained to me that Wilbur Cohen had thought it mighty good strategy to keep the Surgeon General in the dark about the final form of the bill).

On July 22, 1943, Mr. Crain wrote to Dr. Parran as follows:

"AUGUST 5, 1943.

"I have no objection to your publishing my letter of July 17 about the Wagner-Murray-Dingell bill, except that for purposes of publication I should prefer that the following sentence in the second paragraph be omitted: "Whatever its origin, it is not an administration bill, and I did not see it before it was introduced.' "

The letter was finally printed in Hospital Management, August, 1943, on page 16 without the significant sentence revealing how the Surgeon General had been double-crossed by Falk and his associates.

Dr. SHEARON. The bill was written in the Social Security Board. It was gotten into Congress through the A. F. of L. Wilbur Cohen, I was told, at the time took it over to the A. F. of L. and they all sat down together and they rubbed their hands and people at the A. F. of L. said, "Well, what have you got, Wilbur?" And Wilbur said, "Here it is," and handed it over, and from that point on it was handed to Senator Wagner and was introduced.

I took that bill as printed, and I compared it with the bill that had been sent to the Public Health Service to sell them the idea of a social-security bill that was to have the support of the Surgeon General. I have a photostat here of my memorandum. It is 3½ pages long, and I think, again for the legislative history of this whole business, I should like to have that incorporated.

I want to read at this point my own memorandum which is dated July 29, 1943. By that time I was able to study this bill, and I was also able to study and go through the draft that had been sent to the Public Health Service. I said:

> It is important to the Public Health Service, insofar as future efforts at interagency cooperation are concerned, to appreciate fully what happened in connection with the second Wagner health bill. The sequence of events is reminiscent of the pattern followed when the first Wagner health bill was introduced in 1939. Not only was the Service excluded from the last-minute deliberations as the omnibus bill was put in final form for introduction by Senator Wagner, but it was denied a part in crystallizing the language of title IX. Indeed, the Service was led to believe that the draft of title IX was in rough shape and could not be introduced without the work of Public Health Service technicians and of lawyers. However, 30 of these rough sections were actually used as they were by Senator Wagner, without benefit of technicians and lawyers. Until the bill was introduced, the fiction was preserved that the Public Health Service was to have a voice in the proposals whereas, in reality, the Service had for months been kept in the dark about the provisions of title IX intended for Congress and had been permitted to see only a specially drawn version containing a confusing intermixture of inconsistent sections interspersed with inexplicable gaps.

Senator **Donnell.** Would you like to have this memorandum inserted in the record.

Dr. **Shearon.** I should like to have the memorandum inserted in the record.

Senator **Donnell.** It will be so inserted, in full.

(The memorandum referred to is as follows:)

FEDERAL SECURITY AGENCY,
UNITED STATES PUBLIC HEALTH SERVICE,
Bethesda, Md., July 29, 1943.

MEMORANDUM

To: Mr. Perrott.
From: Marjorie Shearon.
Subject: Comparison of the Wagner bill (S. 1161) with the Social Security Board draft bills, dated March 8 and May 25, 1943.

During 1943, two social security legislative proposals were drafted containing provisions (written by or under the direction of I. S. Falk) for a comprehensive health insurance program: One was the Wagner bill (S. 1161), also known as the A. F. of L. bill, which was introduced without referral to the Public Health Service, the other, which may be designated as the Social Security Board bill, was referred to the Public Health Service in two successive drafts.

The Wagner bill, consisting of 90 printed pages, is divided into 17 major sections covering 10 new or amended titles in the Social Security Act. The Social Security Board bill contains parts of 4 of the 17 major sections in the Wagner bill, or the equivalent of about 34 printed pages. The Social Security Board bill was obviously incomplete and disjointed, with neither preamble, summary of scope, nor closing section. (See attached comparisons of the two bills.)

The first rough draft of the Social Security Board bill, dated March 8, 1943, was sent to the Surgeon General on March 17 with the following letter from Mr. Altmeyer:

I am sending you a rough draft of a bill which we have drafted in connection with the health section of the recommendations we will probably make to Congress. This is in very rough shape, even without the benefit of legal advice, but I thought it would be helpful if you and I could discuss some of the important policy questions involved before we had our respective technicians undertake to put the language in more exact form.

This draft covered only title IX or what amounted to 1 of the 17 sections which later appeared in the Wagner bill. It was apparent this title was part of a larger bill, and the Public Health Service asked for the entire legislation. On May 1, parts of 2 more major sections were sent to Public Health Service, but, as is evident when these fragments are compared with the Wagner bill, there were significant omissions. Furthermore, the drafts sent to the Public Health Service were replete with provisions most attractive to the service, but these did not appear in the bill introduced by Senator Wagner. On May 31 or June 1, the Surgeon General received a revised draft of the Social Security Board bill, dated May 25, 1943, with a letter stating that the Surgeon General's recommendations for amendment of the first draft had been incorporated. Mr. Altmeyer stated the devised draft is "still in very rough shape and has not been revised by the lawyers. * * * However, I thought it best to send you the draft in its present form so that our respective technicians may now begin to spell out the language and the policy for our further consideration."

This revised draft of the Social Security Board bill covered 2 of the 17 major sections of the Wagner bill and part of a third title, but one-third of the provisions of the title IX sent to the Public Health Service differed from, or had no counterpart in, the title IX of the bill introduced by Senator Wagner 3 days later, and no inkling was given to the Public Health Service of the contents of 13 of the 17 major sections of the Wagner bill, that is, of nearly two-thirds of the Wagner bill (measured in printed pages).

Since the Surgeon General is planning to come forward with his own views on war and postwar national health programs and since he and his staff may wish to assume leadership in developing closer public relations with the professions and groups most deeply concerned with a comprehensive health program, it would seem advisable to have a clear understanding of developments thus far in connection with legislative proposals.

In retrospect, and after a line-by-line comparison of the Wagner bill with the Social Security Board bill, it becomes evident that the board for at least some months prior to the introduction of the Wagner bill had been working on two health bills, one in collaboration with the A. F. of L., the other in collaboration with the Public Health Service. The first bill was destined to be introduced as one title in an omnibus social insurance bill; the second was not, presumably, for introduction in Congress, but simply for discussion purposes with the Public Health Service which at no time was permitted to see the drafts prepared for the A. F. of L. and for Senator Wagner.

At no time was the Public Health Service permitted to see the legislative proposals that were designed to bring about a major reorganization of the whole social security program as a result of the introduction of a comprehensive health program. The service did not have access to the provisions setting up the Social Insurance Trust Fund with a board of trustees containing neither the Surgeon General nor any representative of the health field. It is significant that the draft bill sent to the service contained the financial sections of title IX–A immediately before and after the one dealing with the creation of the trust fund but did not include that potent section (969 of the Wagner bill) which deprived the Public Health Service of any direct access to the health funds and which placed extraordinary powers of financial control in the Social Security Board.

The Public Health Service had no opportunity to see the health proposals in their total setting in a comprehensive insurance program. The argument may be advanced that the Service could have no interest in fiscal proposals relating to taxation, amount of funds available for the several component programs, administrative responsibility, coverage for benefits, etc. But the Service has a very real interest in all these matters and should have been consulted about the criteria used for determination of eligibility for health services, the definition of disability, the pressing health needs of the country, and how these needs might best be met.

Furthermore, a comprehensive health program, including medical benefits for all insurance and assistance beneficiaries, must be meshed into all the social security income-maintenance titles, and consequently the Surgeon General, charged with the responsibility for administering the health benefits for the beneficiaries of the several social security titles, should clearly have been consulted when the over-all framework of the new and expanded social insurance program was being set up. It is, perhaps, not unfair to surmise that he was not consulted because he might have objected to the insignificant role assigned to the Public Health Service and the many administrative strictures imposed on the Service.

A single illustration will suffice to show the technique employed to throw the Public Health Service off guard with respect to the legislative proposals. In the Social Security Board bill the division on administration contains two sections, 904 and 905. The first of these contains the customary legislative language relating to appropriations: "There is hereby authorized to be appropriated for the fiscal year * * * a sum sufficient for all necessary expenses of the Public Health Service." There follow four more paragraphs giving to the Surgeon General the type of administrative authority he ought to have with respect to the internal organization of the Public Health Service, subject only to the approval of the Federal Security Administrator. The Public Health Service was led to believe that these were the provisions which the Social Security Board would propose to Congress (see Altmeyer assurances of March 17 and May 29). But not a single one of these provisions in section 904 of the Social Security Board bill was actually incorporated in the Wagner bill.

A similar technique was used with one-third of the provisions in title IX submitted to Public Health Service for criticism. Seventeen alluring provisions in the health title which the Public Health Service received on May 31 were not in the Wagner bill which at that very time must have been completely crystallized, if not already in the hands of the Government Printer. News releases, giving a summary of the provisions of the Wagner bill, had been written, mimeographed, and mailed to the press for release on June 3, and on June 2 there appeared in the New York Times a statement that Senator Wagner was expected to introduce a bill including, among other proposals, provisions for a medical care and hospitalization program to be administered by the Public Health Service. Thus, on the very day (May 29) the Social Security Board was sending a health bill to the Public Health Service for revision, the Wagner bill, full blown and containing quite different health provisions, was on its way to the floor of the Senate without the Service having had any opportunity to see a single draft of this omnibus legislation which had been months in the drafting and which vitally affected the Service.

In passing, it may be pointed out there was little reason for submitting the May 25 draft of title IX to the Public Health Service because the suggestions which the Surgeon General made in March to integrate titles V, VI, and IX and to provide for a hospital program were not incorporated, despite Mr. Altmeyer's assurances that such action had been taken.

It is important to the Public Health Service, insofar as future efforts at interagency cooperation are concerned, to appreciate fully what happened in connection with the second Wagner health bill. The sequence of events is reminiscent of the pattern followed when the first Wagner health bill was introduced in 1939. Not only was the Service excluded from the last-minute deliberations as the omnibus bill was put in final form for introduction by Senator Wagner, but it was denied a part in crystallizing the language of title IX. Indeed, the Service was led to believe that the draft of title IX was in rough shape and could not be introduced without the work of Public Health Service technicians and of lawyers. However, 30 of those rough sections were actually used as they were by Senator Wagner, without benefit of technicians and lawyers. Until the bill was introduced, the fiction was preserved that the Public Health Service was to have a voice in the proposals whereas, in reality, the Service had for months been kept in the dark about the version of title IX, intended for Congress and had been permitted to see only a specially drawn version containing a confusing intermixture of inconsistent sections interspersed with inexplicable gaps.

Dr. SHEARON. It shows what has come out repeatedly, that Commissioner Altmeyer is not a responsible Federal official, and in this case he double-crossed another Federal official who was of equal rank with himself, namely the Surgeon General, Dr. Parran.

I have here a document, but I do not think it is necessary to insert it in the record, but I would like to show you this. It is a very careful analysis. line by line comparing the Wagner-Murray-Dingell bill as it was introduced, and the parallel bill that was carried on for several months called the Social Security Board bill, a line by line comparison, and a summary showing the gaps that were left in the bill presented to the Surgeon General, the omissions that would have indicated how the bill was to be administered, how it was to be financed. All those important matters were entirely left out so that you had only a skeleton thing given to the Public Health Service.

Senator DONNELL. If you have no objections, I would like to put this into the record also.

Dr. SHEARON. Well, I think it is an important part of the history of this legislation.

Senator DONNELL. This will be incorporated in the record beginning with the page headed "Comparison of Wagner bill (S. 1161) with Social Security Board bill." That consists of 10 sheets. It will be incorporated in full. Have it placed in tabular form as it appears there, too.

(The document referred to is as follows:)

Comparison of Wagner bill (S. 1161) with Social Security Board bill

Section	Wagner or A. F. L. bill introduced in Senate, June 3, 1943, without referral to Public Health Service	Social Security Board bill referred to Public Health Service Mar. 17, 1943, and May 29, 1943
1	Preamble	No counterpart in bill referred to Public Health Service.
	Title I-A: Unified national social insurance system—scope.	Do.
2	Title I-B: A national system of public employment offices.	Do.
3-7	Title II: Federal old-age, survivors, and permanent disability insurance benefits.	Do.
8	Title II-A: Social-security protection to individuals engaged in the military service.	Do.
9	Title VIII: Federal unemployment insurance, temporary disability, and maternity insurance benefits.	Do.
10	Title VIII-A: Unemployment compensation allowances on termination of military service.	Do.
11	Title IX: Federal medical, hospitalization, and related benefits. This title contains 33 sections and subsections.	Title IX: Federal medical, hospitalization, and related benefits. This title contains 47 sections and subsections, 17 of which differ from, or have no counterpart in, the Wagner bill.
12	Title IX-A: Federal social insurance contributions. This title contains 11 sections.	Title IX-A: Federal social-insurance contributions. This title contains 10 sections essentially the same as 10 of the 11 sections in Wagner bill, but the significant sec. 969 on the creation of the Federal social insurance trust fund and of a board of trustees without health representation was omitted from bill shown to Public Health Service.
13	Miscellaneous provisions in title XI of Social Security Act.	Most of sec. 13 of Wagner bill was in March 8 draft of Social Security Board bill; part dealing with Federal Advisory Council was omitted from May 25 draft.
14	Title XII: Unified public assistance program	No counterpart in bill referred to Public Health Service.
15	Repeals sections of Internal Revenue Code	Do.
16	Effective date	Social Security Board bill and Wagner bill identical.
17	"This act may be cited as the 'Social Security Act amendments of 1943'."	Not in bill referred to Public Health Service.

Comparison of health provisions in Wagner bill and in Social Security Board bill

Wagner bill (S. 1161) [1]	Social Security Board bill [2]	Remarks
Title IX: Federal medical, hospitalization and related benefits:	Title IX: Federal medical, hospitalization and related benefits:	
901a. Primary medical and hospitalization benefits.[3]	901a. Identical with Wagner bill.[3]	Same in both bills.
901b. Dependent's medical and hospitalization benefits.[3]	901b. Identical with Wagner bill.[3]	Do.
	902. Federal medical and hospitalization benefits for old-age, survivors and disability beneficiaries.[4]	Not in Wagner bill. Would give Federal medical and hospitalization benefits to persons not currently insured who had been in insurance system.
902. Maximum hospitalization benefits. Same as 903, Social Security Board bill.[3]	903. Same as 902 of Wagner bill.[3]	
Administration:	Administration: 904a–e. No counterpart in Wagner bill.[4]	Social Security Board bill has 2 sections (904 and 905) on administration, of which the latter is same as Wagner bill.
903a–c. Same as sec. 905 a–c, Social Security Board bill.[3]	905 a–c. Same as sec. 903 a–c in Wagner bill.[3]	Sec. 903. Social Security Board bill, sec. 904 has no counterpart in Wagner bill. It changes name of U. S. Public Health Service to U. S. Health Service and the title of the Surgeon General is similarly changed. The Surgeon General apparently is given more authority than under the Wagner bill and, in this section—which is not consistent with sec. 903 (b) in the Wagner and Social Security Board bills—it appears he is to report to the Federal Security Administrator, not to the Social Security Board as provided in the Wagner bill. But actually, in both bills, final authority is placed in Social Security Board.
904a, b. National advisory and hospital council. Practically same as sec. 906, Social Security bill.[3]	906a, b. Practically identical with sec. 904, Wagner bill.[3]	Practically same in both bills.
905 (1)–(12). Guiding principles and provisions for administration.[3]	907 (1)–(12). Same as sec. 905, Wagner bill.[3]	Same in both bills.
906. Hearings and appeals. Differs from social security board bill provisions in sec. 908.[5]	908. Hearings, appeals and penalties. Differs from provisions in sec. 906, Wagner bill.[4]	Sec. 908 in social security board bill deals with same subject as sec. 906 in Wagner bill, but content is quite different. Social Security Board bill gives more power to Surgeon General, authorizes final appeal to him in case of disputes with physicians, hospitals, etc.
	909. Continues appeals procedure of sec. 908, authorizing Surgeon General to disqualify a physician from participating in program if his services are found to be of an "unsatisfactory nature" and to terminate specialist designation for cause.[4]	No counterpart in Wagner bill. Places final power of adjudication in appeals system in hands of Surgeon General, but the causes for friction and dissatisfaction in administration might well lie in rules and regulations promulgated, or insisted upon, by Social Security Board against better judgment of Surgeon General.
907a, b. Participating hospitals. Same as sec. 910a, b of social security board bill.[3]	910a, b. Same as sec. 907a, b of Wagner bill.[3]	Identical in both bills.
908. Application for hospitalization benefits. Same as sec. 911, social security board bill.[3]	911. Same as sec. 908, Wagner bill.[3]	Do.
909. Relations with workmen's compensation benefits. Same as sec. 912, Social Security Board bill.[3]	912. Same as sec. 909, Wagner bill.[3]	Do.
910a, b. Provision of benefits for noninsured persons. Same as sec. 913a, b, Social Security Board bill.[3]	913a, b. Same as sec. 910a, b of Wagner bill.[3]	Do.

Footnotes at end of table.

Comparison of health provisions in Wagner bill and in Social Security Board bill—Continued

Wagner bill (S. 1161) [1]	Social Security Board bill [2]	Remarks
Administration—Continued	913c. Surgeon General directed to notify Social Security Board of obligations incurred so that Board may authorize disbursements.[4]	Sec. 913(c) of Social Security Board bill clinches control of Social Security Board over Surgeon General by specifying he must obtain Social Security Board approval for obligations incurred against moneys in trust fund for medical care and hospitalization benefits for noninsured persons, e. g., recipients of public assistance or members of Blue Cross plans having contracts approved by Surgeon General.
911a. Limitations on general medical and laboratory benefit. Same as sec. 914(a) in Social Security Board bill.[3]	914a. Same as sec. 911(a) of Wagner bill.[3]	Identical in both bills.
911b. Slightly different from sec. 914(b) in Social Security Board bill.[3]	914b. Slightly, not significantly, different from sec. 911(b) of Wagner bill.[3]	
912. Report concerning dental, nursing, and other benefits. Same as sec. 915, Social Security Board bill.[3]	915. Same as sec. 912, Wagner bill.[3]	Do.
913a, b. Medical care and hospitalization account, same as sec. 916a, b, Social Security Board bill.[3]	916a, b. Same as sec. 913a, b, Wagner bill.[3]	Do.
913c [5]	916c. Paragraph (1) of this section same as 913 (c) of Wagner bill; paragraph (2) has no counterpart in Wagner bill.[4]	
913d. Same as sec. 916 (d), Social Security Board bill.[3]	916d. Same as sec. 913 (d), Wagner bill.[3]	
913e [5]	916e. First half of this paragraph same as 913 (e) of Wagner bill, but 6 significant lines are added that would greatly affect Public Health Service funds for medical care and related benefits.[4]	Social Security Board bill would permit Public Health Service to use for medical care and related benefits only specified percentage of taxes collected by Social Security Board for social insurance. If this percentage were inadequate for health program Public Health Service could not get funds unless Congress authorized transfer of additional moneys from trust fund or made appropriation from general taxes. Result: great fluctuation from year to year in amount available for health; program planning would be difficult.
	916f, g. No counterpart in Wagner bill.[4]	These paragraphs of sec. 916 set up three parts in the medical care and hospitazation account of social-insurance fund. Of total credited for this account, 60 precent would be allotted to medical care benefits, 33⅓ percent to hospitalization benefits, and 6⅔ percent to laboratory benefits. Transfers between the separate funds are permitted under certain conditions, at discretion of board of trustees.
	917a–c. Rates of payment for medical benefits. No counterpart in Wagner bill.[4]	Provides that Surgeon General and Social Security Board jointly shall determine how much there is likely to be in medical care and hospitalization fund and what rates should be paid to physicians and hospitals.
914. Rules and regulations. Same as 918 (a) of Social Security Board bill.[3]	918a. Rules and regulations. Same as sec. 914, Wagner bill.[3]	Identical in both bills.
	918b. No counterpart in Wagner bill.[4]	Provides that in case of disagreement between Surgeon General and Social Security Board, Federal Security Administrator shall act as referee.
915a–h. Definitions. Same as sec. 919a–h in Social Security Board bill.[3]	919a–h. Same as sec. 915a–h in Wagner bill.[3]	Sec. 919 (h), by definition, ties eligibility for medical care and hospitalization benefits to insurance status. Thus an insured person whose earnings fell below certain specified amounts would be ineligible for medical benefits.

Footnotes at end of table.

Comparison of health provisions in Wagner bill and in Social Security Board bill—Continued

Wagner bill (S. 1161) [1]	Social Security Board bill [2]	Remarks
Title IX–A. Federal insurance contributions:		
Subchapters A–E, sec. 960–968. Essentially same as in Social Security Board bill.[3]	Subchapters A–E, sec. 960–968. Essentially same as in Wagner bill.	Wording slightly different in sec. 966 (b)–4 and 968 (b).
Subchapter F. Federal social insurance trust fund:[4] Sec. 969.	No counterpart of subchapter F in Social Security Board bill.	This is the most significant provision in the Wagner bill for the Public Health Service because it gives control of trust fund to board of trustees on which Surgeon General is not represented. This entire subchapter, sec. 969 with 9 subsections, was not shown to Public Health Service in advance of introduction of Wagner bill.
Sec. 970. Same as sec. 969 of Social Security Board bill.[3]	Sec. 969. Same as sec. 970 of Wagner bill.[2]	
Sec. 13. Same as sec. 14 of Social Security Board bill.[3]	Sec. 14. Same as sec. 13 of Wagner bill.[3]	Identical in both bills.
Sec. 1108. Powers of the Board and Surgeon General. Same as Social Security Board bill.[3]	Sec. 1108. Same as Wagner bill.[3]	Do.
Sec. 1109. Administration. Same as Social Security Board bill.[3]	Sec. 1109. Same as Wagner bill.[3]	Do.
Sec. 1110. Determination of disability and rehabilitation of disabled beneficiaries.[3]	Sec. 1110. Same as Wagner bill.[3]	Do.
Sec. 1111. Grants-in-aid for medical education, research, and prevention of disease and disability.[3]	Sec. 1111. Same as Wagner bill.	Do.
Sec. 1112. Federal advisory council.[5]	No counterpart in Social Security Board bill draft of May 25, 1943, although it had been in draft of March 8, 1943.	In the March 8, 1943 draft of Social Security Board bill there was a sec. 1110 on Federal advisory council, but this was omitted from the May 25, 1943 draft.
Sec. 1113 [5]	do	This section relating to benefits under titles II, VIII, and VIII–A appears to be out of place.
Title XII. Unified public assistance program:		
Sec. 1201–1206 [5]	No counterpart in Social Security Board bill.	This title is significant to Public Health Service (though never discussed with the Service) because "assistance" is defined to include "medical service for needy individuals" where provided in State plan.
Sec. 15. Repeals significant sections in revenue code.[5]	do	This section transferring tax collection functions from Bureau of Internal Revenue to Social Security Board was not discussed with Public Health Service although the collection of taxes for health benefits was involved.
Sec. 16. Effective date of several titles specified. Same as sec. 17, Social Security Board bill.[3]	Sec. 17. Same as sec. 16 of Wagner bill.	

---

[1] Introduced by Senator Robert F. Wagner, June 3, 1943. No draft of this bill sent to Surgeon General; bill not seen by Surgeon General or staff until after introduction.

[2] Draft of May 25, 1943, sent to Surgeon General by Mr. A. J. Altmeyer on May 29, 1943. This draft was said to be in discussion stage to be worked on by technical staffs of Public Health Service and Social Security Board.

[3] Provisions same in both bills, though not necessarily numbered identically.

[4] In Social Security Board bill but differs from, or has no counterpart in, Wagner bill.

[5] In Wagner bill but differs from, or has no counterpart in, Social Security Board bill.

NOTE.—No comment is made on the first 10 major sections of the Wagner bill, since the Public Health Service did not at any time see any version of those sections; they contain references to health provisions, such as definitions, coverage, and administration.

Dr. SHEARON. I have spoken of the fact that Mr. Falk has his plans well made for the administration of this program. Theoretically it was supposed to be administered by the Surgeon General.

It was perfectly obvious, however, from the wording of the bill that that was simply a blind to make the public at large, perhaps to make Congress think that the medical-care program would actually come in under the supervision of the Public Health Service and of the Surgeon General.

We have noted in these bills, as we have gone through them at these hearings, that the ultimate authority lies either in the Social Security Board or in the Federal Security Administrator.

Over and over again, we have seen that the ultimate authority was there, and as a matter of fact when Oscar Ewing testified and Senator Smith pressed him a little on the point, he said the ultimate authority is there; that is, for himself to make final decisions.

Now, Mr. Falk was working out, for years he has been working out, how this program would be administered, and I should know. I was with him for 3½ years. He and his staff studied the administration in other countries and then drew up little tentative drafts. "Well, how would it work here? What would we do about the fee for service and about the capitation method? How would we tax? Would we have a general medical service for the entire population, and finance from general revenues, or would we bring it in under the old Social Security Act?" and so on.

Many hours were spent. Large sums of money have been exhausted in studying the ways in which this could be done to the United States to bring it in line with the recommendations of the International Labor Organization.

I said at one time that I had a copy of a statement that Mr. Falk had made with regard to the administration of the Wagner-Murray-Dingell bill. I have that copy here dated October 12, 1943, after the Wagner-Murray-Dingell bill had been introduced, and the memorandum is headed: "Administration for the Medical Care and Hospitalization Benefits under the Wagner-Murray-Dingell Bill (S. 1161)," and while this is a short memorandum, it covers the high spots of the administration.

From that time Mr. Falk has gone on. He has amplified this thing, and his staff has amplified it, until we get something like this Medical Care Insurance, this Senate Committee Print No. 5 to which I have referred so often which was published in 1946.

That is an amplification of the same sort of thing that he was working out in 1943, and I submit again the essential lack of intellectual integrity in the man when after writing the bill he comes out with a statement like this and says,

> "From inspection of the bill it is evident that it undertakes to set down objectives, policies, general administrative responsibilities, contribution rates, and similar matters which are necessary and essential in any legislation.

Now, I submit that that is using a very innocent method of expression "from inspection of the bill." Then, he goes on to say he would surmise it is to be so and so and so and so. The man has written the bill. Why doesn't he bring it out honestly that he has written the bill?

Senator DONNELL. I suggest that memorandum be inserted in the record, if you have no objection.

Dr. SHEARON. I certainly have not.

(The document referred to is as follows:)

ADMINISTRATION FOR THE MEDICAL CARE AND HOSPITALIZATION BENEFITS UNDER THE WAGNER-MURRAY-DINGELL BILL (S. 1161)

AN OUTLINE AND SOME POSSIBLE ALTERNATIVES

From inspection of the bill it is evident that it undertakes to set down objectives, policies, general administrative responsibilities, contribution rates, and similar matters which are necessary and essential in any legislation. With respect to cash benefits (for old-age retirement, survivors', permanent disability, temporary disability, unemployment, lump-sum death benefits, etc.) it is more or less explicit; the nature of the cash benefits permits this. But with respect to service benefits (medical care, laboratory and related services, hospitalization) it is more general; this is a consequence of the nature of service benefits.

This is the customary pattern in Federal legislative proposals. The details of administration are usually not specified in an enabling act; they are left to the administrative agency to work out. For instance, the present Social Security Act gives the Social Security Board administrative authority to pay the present old-age and survivors' insurance benefits. Under such general authority the Board has established 11 regional offices, 5 area offices and a Baltimore central office for record keeping, and a central Washington Appeals Council with regional referees to hear appeals from insured persons or other claimants. As experience has developed, the Board has decentralized further the administration of the act under the general enabling authority, etc.

Similarly, the Public Health Service has been given general authority to provide necessary administrative machinery for the various programs and has developed its regional and related patterns. The service has established 8 regional offices to carry on the various programs under its jurisdiction. Relationships with State and local agencies follow a number of patterns. Under title VI of the Social Security Act, the program consists, as required by the act, of the granting of funds to State health departments to augment State and local health work. Under the venereal-disease legislation, the authority is more general and permits the direct Federal operation of a facility if this proves desirable, in addition to grants to State agencies. Under this program, six rapid-treatment hospitals are now operated directly by the Public Health Service, while a number of others are operated by local health departments with financial aid via the State health department. However, in many of these latter locally operated treatment centers commissioned officers of the Public Helaht Service do the clinical work. Detailing of Federal personnel to local agencies called the lend-lease program, has been used to a considerable extent during the war as a means of assisting local health departments under the emergency health and sanitation program. In many counties, commissioned officers of the Service are acting as local health officers and using local governmental authority in carrying on their work. In the malaria-control program, which is directed by the Public Health Service, similar mingling of Federal and local personnel has taken place.

It may be assumed that the framework of proposed administrative arrangements will be indicated to Congress by the administrative agencies when they testify before the Congressional committees which will conduct hearings on the bill.

Accordingly, so far as this outline of administration to implement the medical-care benefits proposed by S. 1161 goes beyond what is explicitly provided in the bill, it is based only upon inferences or guesses as to what may actually be proposed by the official agencies. These are particularly uncertain for the medical-care benefits because the bill clearly implies or requires that many features of administration are to be worked out in consultation with representatives of the medical profession, the hospitals, etc. Thus, this outline can be little more than a framework indicating the probable location of functions which need to be performed.

It is safe to make the basic and primary assumption that the medical care and hospitalization benefits will be provided through an administrative pattern in which the maximum possible decentralization will be practiced. There are obvious reasons for this. The medical and hospital services must be readily available to the patient. The personnel and facilities serving the patient must be in the local community where the patient resides. The specifications of the bill build upon the personnel and facilities which are already in existence. Accordingly, it is inevitable that most of the details of administrative management and operation will be not only local but will be developed by adoption of available resources and by adaptation of customary practices.

It may be assumed that administration would operate on four—possibly five—levels: (1) Central, (2) regional, (3) area, (4) State, and (5) local.

CENTRAL ADMINISTRATION

Central administration is assumed for broad and over-all management and policy, for clearances and coordination with other Federal agencies, negotiations with national organizations (professional and lay and public groups), and similar jobs which must be conducted centrally and nationally, and for essential wage records and related "bookkeeping" such as must be conducted centrally for the social insurance system as a whole, for research on needs, program planning and review of operations, for legal advice, budgetary and auditing problems, development of general educational material, etc.; for appeals machinery, etc. Even for these items considerable decentralization may be practical in some cases and necessary in others.

It is assumed that the Surgeon General would lay down, and issue—to regional, State, and local administrative offices—the basic general patterns, rules, and advices. In accordance with the requirements of the bill, these would be issued as a result of agreements as to policy, intent, and methods reached between the Surgeon General and his advisory council. They would also, of course, be in accord with basic agreements reached between the Surgeon General and the Social Security Board on matters which involve areas of administration lodged in the Social Security Board or jointly in the Board and the Surgeon General. There is involved here such matters as concern eligibility for benefits (as determined from basic social insurance records), coordination with other social insurance operations, arrangements for certification of disability, provision for rehabilitation of disabled persons, etc.

As in any extensive program in which operations are decentralized, it is to be assumed that the guides laid down by the central administration would determine the general framework within which the local authorities may operate and, where central guides cannot be explicitly indicated, would leave appropriate latitude for decisions at levels of administration lower than the central.

REGIONAL

Both the Public Health Service and the Social Security Board already operate on a regional basis. It may be assumed that this practice will continue and that the regional directors of the Public Health Service will have responsibility for translating policy decisions and intentions, developed centrally, into the more practical terms required by State and/or local administrative offices in light of the more specific problems at levels closer to actual operations. The regional directors will also serve as coordinating officers among State offices and agencies. Also, the offices of the regional directors will serve as central points for the receipt and interpretation of information concerning problems, needs, operations, etc., which have to get back to the central administration in order to keep Washington adequately informed of what is going on at the State and/or local levels. The regional directors would presumably also have a large share in the work of coordinating Public Health Service operations (as between the public health and the social insurance programs), and between the Public Health Service and other national or State agencies whose operations at State and/or local levels impinge upon the medical care programs of the national social insurance system.

AREA

The old-age and survivors insurance system now has five area offices but does not have State offices. Whether such area offices are necessary if State offices are established is not entirely clear at this time. They may be of some assistance in decentralizing the work of the central office which involves more volume than State or regional subdivisions make economical.

STATE

The bill is not explicit as to the use of States as the major administrative areas or units. It does, however, explicitly provide that in carrying out the duties imposed upon him to arrange for the availability of the medical and hospital benefits, the Surgeon General of the Public Health Service is authorized to make agreements and (after approval by the Social Security Board) to enter into contracts with various agencies including "appropriate agencies * * * of any State * * *" [903 (b)].

The geographical allocation of funds available for the payment or provision of benefits will probably compel—at the outset—the adoption of a State-by-State subdivision of the country. This may be necessary in solving relations between the source of the social-insurance income and its allocation for disbursement purposes.

It is assumed here that one of the first major steps to be taken in the development of an operating program will be to use the States as establishing generally useful administrative units. This is not intended to imply adoption of hard and fast State boundaries on local operations—especially with respect to provision of benefits for local areas which cut across State lines; such inflexible use of geographical lines would defeat an important advantage of a national system.

It is further assumed that nationally, or at least in the case of most if not all States, the development of administrative machinery at the local levels will actually develop as an outgrowth of administrative organization at the State level. One possible alternative, of course, is that an existing State agency (e. g., the State Department of Health) may become the primary operating arm of the Public Health Service, or that in some States an appropriate State agency will be developed to serve this purpose. Another possible alternative is the development of a new agency—or a new type of agency—for a State. This may be particularly significant if the administration at this level should be such as operates through full-time administrative offices but with the advice and active participation of a representative board, commission, or advisory body which includes representatives of various State agencies (health, welfare, hospitals) and of various specially interested groups in the population (labor, employers, agriculture, medical, and hospital associations, etc.).

The need for the coordination of the medical and hospitaliztion program with the existing programs of public health, public welfare, public hospitals and institutions, workmen's compensation, etc., may require that there be as a minimum, a State coordinating body. Moreover, broad agreements as to policy and as to administrative arrangements reached centrally (and applicable nationally) will undoubtedly need more specific State-wide working arrangements to serve as guides to local administration (e. g., agreements with State medical associations as to conditions of practice, methods of payment, rates of payment, etc., to be applicable throughout the State).

For present purposes, and in order to indicate a possible pattern of local operations, it is assumed that—

(1) Each State is a primary administrative unit.

(2) Funds available to pay for benefits have ben allocated among the States on the basis of a formula which deals equitably as between source of the money and needs of the insured population.

(3) Each State has been subdivided into appropriate local areas. (See below.)

(4) Appropriate formulae have been developed, applicable to the local areas of the State, for the allocation of the available insurance funds by areas, for the graduation of rates of payment to practitioners, hospitals, laboratories, etc., (developed principally with and by the professional associations and representatives of the practitioners undertaking to provide insurance benefits), and

(5) Appropriate agreements have been reached, applicable to the local areas of the State, as to the definition and content of benefits, eligibility of practitioners under State law, conditions of insurance practice, procedures for deciding on methods of payment to practitioners, etc. (developed with the State agency, the medical association, the hospital association, etc.—according as the nature of each subject requires and in accord with the centrally developed, national policies and agreements).

LOCAL AREA

The principal operations of the system to provide medical and laboratory services and hospitalization benefits must of necessity be implemented at the local level. It is to be assumed that there will be local offices and officers—empowered to make all necessary arrangements to assure the local availability of the benefit services; to see that the persons eligible for benefits are informed of their eligiblity and able to effect their contacts with the service agencies; to conduct the necessary administrative operations required to pay for services rendered; and to make whatever special arrangements are needed for the continuing operation of the benefit provisions, for the settlement of disputes, and for similar duties.

To what extent the local officers will operate within the framework of policies, guides, rules, and regulations, etc., furnished from Washington through the regional office, or within such a framewwork laid down primarily at the State level in accordance with the national guidance furnished from Washington, cannot be developed at this time.

In view of the wide diversity in circumstances and practices which obtain throughout the United States, no single rule can be assumed in advance as to whether the local area of operation is a uniform political subdivision of a State (county or city), or multiples or fractions thereof, or is an area determined by local geographical circumstances which more properly define an area which is a natural unit with respect to population, the available medical and hospital resources, or both. It is probable that, by and large, the local areas will be the existing political subdivisions or multiples of them, but that in special circumstances specially designed units will have to be used (fractions of a large city, or composite areas in metropolitan regions). Thus, where needed—especially in ladge cities and metropolitan regions, there would probably be two levels of local administration—a city-wide or metropolitan area office and district suboffices below it.

The diversity of jobs to be done at the local level implies that the local administrative officer will operate under the guidance of general policies and rules, and of agreements and decisions of State-wide applicability, and—on local matters—with the advice and counsel of local consultative bodies. For example, the area officer might have an advisory committee which includes representatives of the major groups upon whose advice and with whose participation he needs to work (e. g., representatives of the insured population, the local government, the local health department, the local professional organizations, etc.). Such an advisory body would probably have subcommittees of more specialized kinds, representing special groups and empowered not only to present their points of view but also to act for them in a representative capacity on matters upon which negotiations, policies, contracts, etc., need to be adopted.

At this local level there would, of course, need to be effective coordination between the work of the officer representing public Health Service officer and the work of the Social Security Board officer. Perhaps common offices and coordinated operations would obtain for the two national agencies, so that matters relating to eligibility, wage records, etc., are handled in close coordination with matters concerning the provision of medical and related benefits.

In providing benefits, the following may illustrate the kinds of administrative operations which would be conducted by the local Public Health Service officer—

1. Announce the invitation for physicians to participate in the provision of insurance benefits. He would circularize all local physicians and make available to them appropriate information, instructions, and forms.
2. Provide opportunity for the local physicians to determine the method of remuneration.
3. Negotiate contracts with physicians with respect to the provision of medical services, methods, and rates of payment, etc.
4. Negotiate appropriate contracts with local organized medical groups, local hospitals, laboratories, etc.
5. Through all media available to him, notify the local insured population of the benefit services available. He would publish the lists of available practitioners, organized groups, hospitals, clinics, laboratories, etc.
6. Make available to the physicians, medical groups, hospitals, clinics, laboratories the necessary forms on which they are to keep the records required by the methods of payment which have been elected or agreed upon in the community.

Having been advised of their eligibility for benefits, and perhaps having received an appropriate eligibility card from the Social Security Board, the local insured population would proceed to get their medical care from the practitioners and agencies available under the local arrangements, much as they do now.

If fee-for-service has been elected in the community, patients will go to their general practitioners and obtain services as they do without insurance. The physician will periodically furnish the local office a record of services rendered, and periodically will be paid for them (e. g., monthly or quarterly). If a capitation basis is being used locally, patients will choose their doctors and, upon acceptance by the doctors, will then have a continuing doctor-patient relationship which obtains so long as it is mutually acceptable to the patient and the doctor, and so long as the individual is eligible for benefits. Periodically (e. g., monthly or quarterly) the physician would be paid through the local office in accordance with the number of persons on his list. If a salary method has been adopted locally, eligible insured persons would go to these practitioners for their services as needed; the physicians would be paid according to the agreed salaries. Persons who elect to be served by an organized local group would get their services from that group; the group would be reimbursed according to the mutually agreed contract.

On the advice or recommendation of a general practitioner, insured patients would be served by the specialist selected (usually by the general practitioner with the consent of the patient or his family). The specialists would be remunerated according to the agreed method of payment through the local office.

Patients would go to hospitals on the advice of the general practitioner or the specialist, as they do now, and the hospitals would be reimbursed according to the existing plan or contractual arrangements. The method of paying the hospitals would depend on which method had been adopted. If hospitalization benefit is being provided on a service-benefit basis (for example, by payment to the hospital according to cost of furnishing minimum-essential services), the patient would have no bill to pay the hospital unless he received services or occupied a type of room not included as insurance benefits; the insurance system—through the local office—would reimburse the hospital for services rendered to all insured persons (e. g., monthly or quarterly). If this benefit is being provided on a cash indemnity basis, the patient pays his own hospital bill, gets a receipt and uses it when he files a claim with the local office for reimbursement according to a previously determined per-diem rate. If the patient has assigned his benefit right to the hospital, it files the claim periodically for all persons served during the period.

The local offices (of the Public Health Service, or representing the Service, and of the Social Security Board) would of course have a diversity of other duties—having to do with contribution and wage records, eligibility for benefits, transfer of records with respect to people who move from one area to another, relationships with disability and other social insurance benefits, etc.

Dr. SHEARON. And it was about at the same time, just a little bit later, when this document to which I have referred so often, this document that came out in 1944—and it was signed, mind you, by eight or nine Government officials, and Mr. Falk was among them——

Senator DONNELL. Now, that is the one that is entitled——

Dr. SHEARON. "Principles of a Nation-Wide Health Program," which has been used as a propaganda document and which was referred to on November 19, 1945, when Senator Wagner introduced the bill on the Senate floor. In view of the fact that Mr. Falk has made these statements about not having any favored feeling toward the capitation method, I quote this paragraph which is in the document which he signed in 1944. On page 22 it says:

> Under the capitation method the physician is paid a fixed amount per annum for each person who selects the physician as his regular doctor. The amount of remuneration of each physician thus depends on the number of persons choosing him, but is independent of the amount of work he does for them. The capitation method is readily applicable to the remuneration of general practitioners but would rarely be suitable for the compensation of specialists. It requires much less administrative work than the fee-for-service method.

The same thing again, over and over repeated, that if you have the capitation method it requires much less work. That is perfectly true, but I do not see why Mr. Falk has said that he did not favor this method, and I continue this final sentence:

> It provides an economic incentive to the physician to satisfy his patients and to keep them well.

I will not bother to go into the detailed provisions of these bills. The 1939 bill was dominantly a grant-in-aid bill similar in some respects to the present S. 545. It did very definitely permit the subsidizing by the Federal Government of a State compulsory health insurance plan.

That was really as far as they had gotten at that time, and Mr. Falk himself did not have enough voice in things at that time to come out with the plan which he was able to come out with in 1943 when he had certainly a stronger voice in how this thing was to be done.

Now, in 1944 this bill of 1943 having died in committee, in the Finance Committee, and it being obvious that any bill of this type would probably never be considered by the Finance Committee and there would not be any hearings, it was then decided behind the scenes to try once more on an omnibus bill bringing in a lot of things about veterans so that the 1945 omnibus Wagner-Murray-Dingell bill, the S. 1050, contained a great many provisions that were designed to be attractive to the returning veterans, and it was sort of jokingly said behind the scenes, "Well, they sort of bring this bill in on the coattails of the veterans."

So they introduced S. 1050 in 1945 and again that was referred to the Finance Committee. It was also an omnibus bill with certain changes made, and at that time as I gathered from talks I have had with Senator Murray and with his son, they worked very closely with Mr. Falk and endeavored to make certain changes in the bill as proposed by Mr. Falk, changes which he did not always like.

There was a little effort here in the Senate to have the Senate itself play, or some members, some Senators have, some part in the wording of the legislation. They never did have any great part in it, because, as I say, it was done in the Social Security Board itself.

I need not go into the history of what happened when the President introduced his national health program on November 19, 1945. We have already learned from the testimony that Mr. Falk and Mr. Cohen had at least something to do with the wording of that statement.

I have pointed out that at that time Mr. Truman said that they were not dealing with socialized medicine. I think he probably thought that was true. He had been told it was not socialized medicine, would not lead to socialized medicine.

A number of things happened late in 1944 in connection with these two oncoming bills, as there was greater activity in the Social Security Board somehow to force through some kind of legislation to take advantage of the war situation because of the preoccupation of Congress. People were concerned with other matters, war matters. There was the hope that maybe they could get this bill through and tie it up with postwar programs for health.

I, myself, had been assigned by the Surgeon General, as I have stated before, to work on a postwar program for health in the field of preventive medicine, the program that would be followed by the United States Public Health Service, and during the year 1944 I devoted my entire time to that subject.

During 1944, while the new Wagner-Murray-Dingell bill, that is, the S. 1050, was being written in the Social Security Board, it became increasingly apparent that the Social Security Board intended to take over, I might say, certain portions of the Public Health Service, namely, the revision of public health methods that was headed up by Mr. Perrott.

Now, Mr. Perrott had been associated with Falk since the early '30s. They had worked together on this whole nationalization movement. He and Falk went to the ILO meetings together and so on. It was a very, very close tie-in.

Dr. Parran, on the other hand, did not believe in compulsory health insurance. He did not feel that that was the answer to the health problems of the country, and he stated that he had not been consulted on this S. 1161.

He had stated that very frankly, because he had come in for a great deal of criticism in 1943, just as I had predicted. I said, "If you touch this bill, you will be called the czar of medicine."

That was just about the first title that was applied to him. "He will be the czar of medicine. He has written this bill to put himself up in the world as an important Federal official."

His denials did not have any effect, and a good many people thought that then, and still think so, but at any rate he did come out and make the statement that he had not been consulted.

It was then apparent, coming on again into 1944, that that condition would not be permitted inside the Federal Security Agency with the Surgeon General saying he had not been consulted about this primary health bill for the health program of the country, and with the Social Security Board backing the bill.

Mr. McNutt—Paul V. McNutt—who was then the Administrator of the Federal Security Agency, told Dr. Parran that there must be peace within the family inside the Federal Security Agency and that the Public Health Service and the Social Security Board must get together and must come through with a common view. Well, when it comes to collaborating with the Social Security Board a small and not so powerful such agency as the Public Health Service always gets the raw end of the deal. So in the efforts to collaborate with the Social Security Board the Surgeon General found himself in many instances in a most unfortunate position where he was expected to get along with the Bureau of Research and Statistics and with what they were doing and at the same time he, as a medical man and an experienced health officer, did not believe that it would be an effective way to promote health in the country to pass an omnibus Federal law providing a compulsory health insurance scheme for the entire population.

Well, I said to Dr. Parran at one time during the summer of 1944, "I cannot understand how it is that this program is being developed by a nonmedical man, by a nonmedical bureau which is a part of the Social Security Board which is itself nonmedical. I cannot understand it."

I shall not forget what Dr. Parran said. He said, "Well, if the Administrator says it has to be health insurance, then it has to be health insurance," and he threw up his hands with an exclamation of despair.

I thought that it was unfortunate that a man who knew as much about the field as Dr. Parran should have been put under this kind of pressure from an agency that was not working in the public interest as certainly the Public Health Service was and that he should be forced into an almost untenable position, and in time it did become untenable. It became so this year, but at any rate these things were going on behind the scenes.

It was at that period that the program for the American Public Health Association was being rigged by Dr. Mountin, by Mr. Perrott, Louis Reed, and Mr. Falk, the group that we have mentioned before in connection with that particular job of fixing up that one area in the nongovernmental field, namely, the area of the American Public Health Association, so that it, too, would come through with a recommendation favoring compulsion, and that recommendation came through early in October of 1944.

I have previously said—I am just bringing this in now to complete the picture—that I was working on the 10-Year Postwar Program for Health in the Public Health Service, and I had it ready and turned it in early in October 1944, and it received the entire blessing of the Public Health Service and even of McNutt, strange to say.

I really do not know why he approved the 10-year Postwar Program for Health in view of the fact he was putting this pressure on Dr. Parran to come along with the other, the social security, point of view, but at any rate that plan went to the Bureau of the Budget, and it is there now and is still being used by the Bureau of the Budget.

However, that did not deter the Social Security Board from its plan to somehow get through this type of compulsory legislation, and they were working on it very hard. In the fall of 1944, in order, I think, to be able to say, "Well, we have consulted the other professions, the dentists and the nurses," they went through the motions of calling an interdepartmental meeting of nurses and dentists in the Federal Government and other health officials, and some representatives from the outside.

They had a meeting in October stating that they would like to have the recommendations of these professional groups with regard to what they would say about dentistry and nursing in the forthcoming bill that they were preparing, which eventually came out as S. 1050. They had a goodly number of representatives at this meeting which Mr. Falk called in October, but later on in the same week he called together six members of the staff and said, "Well, we will have to do all of these things, call in these people and talk with them and have a study, and so on, but we know what we are going to say. We have the material in our own files."

That statement by Mr. Falk that day resulted in the resignation immediately over the week end of the woman who was to have made the nursing study for him. She, I learned later, was a very fine and honorable woman. I had not known her up to that time, although Mr. Falk states that I was responsible for her resignation. That is absolutely untrue. The reason I did not know her—and anyone who knows me would know certainly that I am telling the truth when I say the reason I did not know her was she had been associated with Michael M. Davis for 17 years, had been on his staff, and she came to the Social Security Board with Mr. Falk. Consequently I had never had any desire to meet her. I saw her once at hearings on some health bill, but except for just meeting her I had nothing whatsoever to do with her.

This woman was Miss Margaret Plumley, and I mention her name because she is a very fine woman and she saw through these two men at last after 17 years' association with Michael M. Davis and 2 years with Mr. Falk, and resigned with no job in sight. She made this statement on November 12, 1944:

My Dear Mr. Falk: I left the office yesterday noon immediately after the meeting in order to give myself an opportunity to think over quietly my attitude toward the method you have outlined for the conduct of what you term a

> "nursing study" and the way in which you appear to be planning to use the technical staff and the consultants.
>
> I have come to the conclusion that our ideas of what constitutes an honest study and a proper use of consultants and professional staff are too divergent for me to continue working in the Bureau. In coming to this decision I have been influenced by a number of factors, some of which have been troubling me for months.

She goes on to state that she had great distrust for the type of work they were doing, for their research reports, for the way in which the time of the staff was spent. She distrusted the ability of Mr. Barkev Sanders.

I might say professional members of Mr. Falk's staff from the time Sanders was appointed protested his inability, his lack of professional competence, and yet he is now receiving around $8,000 and is in charge of the health studies on Mr. Falk's staff. I think there would be many people who would say he is entirely incompetent, and Miss Plumley said so. She said one of the things that had troubled her, and, of course, she was writing Mr. Falk, "was your responsibility for Mr. Sanders' position as director of the Division of Health and Disability Studies, and your retention of him in that position although his incompetence is clearly evident."

She said further one of the things that had been troubling her was "disillusionment as to the character of the work done in the Division and the methods under which the work is carried on * * * I have come to have a profound distrust of the material published by the most active section in our Division."

I might say that Miss Plumley was very highly regarded by Mr. Falk. He gave her the highest rating it is possible to get in the Federal Government. He rated her work as excellent. After she left he tried very hard to get her to remain—to come back.

She would not even come back into the building. She left this resignation on Mr. Falk's desk early Monday morning and she walked out, and that was the end of it. She left the Federal Government and did not want to have anything more to do with the Government.

I think it is unfortunate when honest competent Americans feel they have to leave the Federal Government because of the kinds of things Federal officials do.

That was on November 12, 1944. On March 23, 1945, Ruth E. Stocking, M. D., resigned. She had been on Falk's staff for 7½ years. She went to his staff just a month or two before I, myself, did in 1937.

She was the only M. D. on his staff. She came into the Federal Government in the hope of doing a real job and she stuck it out longer than the other members of the staff, still in the belief that there was a job to be done by a medical person in the Social Security Board, and there certainly was a job, but it was impossible to do it.

On March 23, 1945, she wrote to Mr. Falk:

> After nearly 7½ years of association with you, first in the Division and later in the Bureau, it seems appropriate for me to state my reasons for resigning somewhat more fully than would be possible on the routine resignation form.
>
> From time to time during the past years I have tried to make clear to you my growing sense of distrust for much of the work we do. I have discussed with you my belief that the Division was not meeting its responsibilities in regard to much work that needed doing. I already had grave misgivings as to the fruitfulness of the Division's work when Mr. Sanders was made its chief more than 5 years ago.

That was in 1940, and I might say, at that time when Mr. Falk himself moved up to become the Director of the Bureau of Research and Statistics, it was obvious that he was grooming this statistician to take his place as the head of the Health and Disability Studies. The members of the senior staff, including myself, went to Mr. Falk and urged him not to appoint Sanders because of Sanders' obvious lack of professional competence, his inability—in other words, his willingness to make statistics go any way that Mr. Falk wanted them to go.

It was not what we needed in the Federal Government, and we should not be paying out public funds to a person of that sort. We protested, therefore, his being elevated to that position.

There were persons on the staff who were competent. Mr. Falk went right straight ahead and elevated Sanders.

This did not affect me in particular, because I wasn't under Mr. Sanders' supervision, but it did affect a number of other persons on the staff, and I think that it is important to point out that Mr. Sanders is still in this position; that he was one of those who was sent on a mission to Japan as a representative of the United States Government, a man who for years has been known to be incompetent and not to care what he does with Government reports, reports to Congress, reports to the general public. We felt, the senior members of the staff felt, that he had originally been put in that position because of his pliability rather than because of his professional competence.

Dr. Stocking goes on to give a number of reasons for feeling a great distrust in the work that was being done, and she points out one thing after another which I needn't go into detail about, but the fact that there is a document of this sort in existence is important.

She refers to the "inadequate advice that was given to Rhode Island" in connection with the Rhode Island cash-sickness law that Mr. Falk had a great deal to do with having enacted. She points out what Miss Klem would be doing out in California.

She went out there for a month to work with Governor Warren in the hope that there might be pushed through in that State a compulsory health-insurance law. All this is going on behind the scenes inside the Federal Government in a propaganda machine that is unbelievable if you have not been inside and watched what is going on.

Miss Klem has been active throughout more than a decade in that sort of work and Dr. Stocking refers to that.

I might say it was about this same period—as long as I am speaking with regard to the things that senior staff members called attention to when they were resigning—Mr. Falk had seen fit at that time and only recently to say he had personnel difficulties. Well, of course he had personnel difficulties. All administrators had a turn-over in personnel. Everybody has a turn-over in personnel.

This was somewhat different from ordinary turn-over difficulties. These were direct charges by senior professional staff whose work had been highly rated, who were well regarded inside the Government, charges that their supervisor lacked integrity. It did not matter how much scientific training he had, how capable and brilliant he was, how clever. Everybody says he is clever. Those things don't matter. We can do with a little less cleverness and perhaps a little less scientific training, but in a Bureau of Research and Statistics that is putting out reports that affect the entire population of the United States, we need integrity above all things first and foremost, and that is what the staff felt and that is why the staff resigned.

The people he has with him now are certainly—well, I don't hesitate to call them—second raters, to say the least. Most of them are not highly trained professionally. They have been boosted up. Many of them were simply people who were way down the line when the professional trained staff was there and Mr. Falk could not get any other people to come in.

The Bureau got a bad reputation so he raised people into the positions where they are now getting seven and eight thousands dollars a year. It is a sheer waste of the taxpayers' money.

I want to give one additional illustration from my own experience with Mr. Falk. Before I left his staff he called me in and asked me to write a report for a magazine known as Administrative Medicine. The editor is Dr. Emerson, who was on the faculty at Columbia University. Mr. Falk said that he was very busy and did not have time to write the article and would I do it for him.

It was quite a lengthy article and I so did. I prepared it on Government time with Government secretaries on Government paper.

Senator Donnell. Whose name was it to appear under?

Dr. Shearon. Well, when I turned the article in Mr. Falk put our two names on it. I had no intention of letting my name appear on it, but I did not say anything at that moment because I was a great deal more worried about something else.

I had already made up my mind by that time that I was going to get out of a bureau like that. I was then engaged in working on a document for the Board, for Congress, on old-age insurance, and I wanted to finish that before I left. Each one of us had some particular piece of work that we were interested in so I did not fully state what was on my mind, but I had a worry, and this was it.

As all the other members of the staff had done, I had complained about maladministration, the waste of the taxpayers' money, and dishonest reports, and I had done it through the proper administrative channels, namely, first we had a staff meeting with Mr. Falk and had expressed our grievances in regard to maladministration, and we got absolutely nowhere. As a matter of fact, he called a subsequent meeting and shook his finger at us and said, "I order, I command," as though we were in Hitler's Germany or in Russia, and it didn't set well with the professional staff any more than it would set well with a group of lawyers or any other professional group.

We decided to get out of a situation like that, but in the meanwhile we had our jobs to finish up.

Well now, as I say, we had first complained that way and then we had complained to the personnel office as we had a right to do under civil service. We were civil servants and we had a right under the law to go to the personnel office and complain, which we did, and we were told by one of the top personnel men in the Government, Robert Barnett, a very fine man—he said:

> I know the conditions in that Bureau are terrible. I have no direct line of responsibility. I can do nothing about it. I will help to get you out and I will protect your personnel folders from the things that Mr. Falk is likely to do.

In other words as a supervisor Mr. Falk could put damning statements into our personnel folders, and the Director of Personnel said he would protect us against that.

As a matter of fact, Mr. Falk did threaten to put things in personnel folders and he did put them in some personnel folders, but that is something else again.

However, I had complained about his corrupt administration, and then shortly after that complaint he called me to the office and asked me to write this article, and when he asked me in, when he asked me to write the article he stated that there would be a little honorarium in it for me that would be a help to me to pay my Christmas bills, and he would throw other little chances my way to make extra money on Government time.

I wrote the article, leaving my name off, and simultaneously asked to be transferred out of the Bureau of Research and Statistics of which Mr. Falk was then Assistant Director.

I did not get out right away. As a matter of fact, I went to the Public Health Service, had a long talk with Dr. Parran and they did not have the funds at that time and it was a year or more after that before I finally got out. However, there was a delay in the publication of that article, and it had not come out by the time I left, so when I left I turned over the manuscript to Mr. Falk.

I asked to have my name taken off it; that there be no credit given to me in the footnotes because I did not want to have my name connected with his in any way, and I washed my hands of the article and turned it over. He subsequently gave it to Mr. Sanders to bring up to date.

The article came out in this magazine called Administrative Medicine, and it finally bore the name of Mr. Falk alone.

In connection with an entirely different matter I had occasion to refer to the fact that Mr. Falk had asked me to do this on Government time. I had done it on Government time. I had been paid by the Government with a Government pay check, and I referred to the fact that there was a Federal law which says that you may not receive money from other sources when you are being paid full time in a Government agency, and that is 5 United States Code 66.

I referred to the fact that Mr. Falk had no right to suggest that I receive an honorarium for the work I did. I had mentioned that in some other connection and it got back to Mr. Falk. He came out with this extraordinary remark that he was having a check sent to me.

It was a year after I left the Board, and sure enough on October 22, 1942, I received a check from this Administrative Medicine and in the letter it says: "This payment is made at the suggestion of Mr. I. S. Falk in whose name the above-mentioned article was prepared."

I wrote a letter to the editor, Mr. Bagley, Thomas Nelson Sons, on the 15th of March 1945 and I told the story. I was about to return the check and I was advised to keep it; that it might some day be good evidence against a Federal official who would propose this sort of thing to a Federal employee.

Senator Donnell. Do you have the check?

Dr. Shearon. The check is right here. This is the original check. I have it here and I submit it. I do submit we don't have to show a Federal employee has done something to the tune of a million dollars. Fifty dollars or $25 is just as good if he is breaking a Federal law, and I submit if he did not himself take the money, he proposed it to a member of his staff, and it was a crooked and dishonest thing to do.

Furthermore, a check of an equal amount was sent to Barkev Sanders at the same time and I should like to have it looked into whether or not Sanders cashed this check. I would not mind having this letter read into the record at this time.

Senator DONNELL. Don't you think you have given us the facts there sufficiently on that?

Dr. SHEARON. All right. I am giving you what was going on behind the scenes just before the 1945 S. 1050 was written, and by that time the original professional staff had gotten out in protest.

Then S. 1606 came along for the purpose of taking out just the benefits part out of the S. 1050 with the hope of having the hearings before this committee instead of the Finance Committee, and I think that we know current events sufficiently so I need not go into that, and I believe that that gives practically the entire history.

I have a great deal of documentation. I have one other thing I would like to introduce, namely, a paper by Dr. Maurice Friedman which has just appeared in the Nation's Business for May 1948. The title is, "Doctor, My Statistics Feel Funny." It is a popular article, and Dr. Friedman's testimony in regard to the statistics that have been coming out of the Federal Security Agency is there.

Senator DONNELL. This article by Dr. Friedman is received for the record and will be incorporated in full.

(The article referred to is as follows:)

[Reprinted from Nation's Business, May 1948 issue]

DOCTOR, MY STATISTICS FEEL FUNNY

(By Dr. Maurice Friedman)

DRAFT FIGURES HAVE BEEN USED TO PROVE US A NATION OF WEAKLINGS AND CRIPPLES. LET'S LOOK AT THE FACTS

You're sick. I'm sick. We are all sick. We are a nation of cripples.

Who says so?

The Federal Security Administration, a governmental agency. So it must be true. Federal officials would never mislead the public and the Congress—or would they?

For many years we have been told that the health of this Nation is deplorable, that large segments of our people go entirely without medical care, and that our present system of medical services is woefully inadequate. Indeed, we have been told that the situation is a national emergency.

We cannot afford to waste time experimenting with modifications of our present system or with voluntary health insurance. We must act without delay, and act radically. We must scrap the private practice of medicine altogether and adopt a compulsory national health insurance directed by a Federal agency in Washington.

If you doubt this, take a look at the "shocking" picture revealed by the draft statistics. Just think, "one-half of our young men, in the flower of life, unfit to bear arms for their country." These sensational words were set to music—the music of emotion. The Federal Security Administration supplied the words and many prominent men sang the tune: William Green of AFL, James B. Carey of CIO, Leon Henderson, Harold Ickes, several Senators, and even our President. Leading newspapers joined in the song. Their Washington correspondents dutifully sent in official bureau hand-outs.

What are the facts?

In the first place, it is not true that one-half of our young men were unfit to bear arms. Even at this date the Selective Service System has not finished compiling and tabulating all of the data. But we can get an idea of the true situation by examining a period for which the data have been completed. From December 7, 1941, to December 31, 1943, the Selective Service System examined about 10,000,000 men. Of these, they rejected about 36 percent. At the same time, however, 2,700,000 men volunteered for service and were accepted by the Army, Navy, or Marine Corps. Therefore, the total number of men examined for military service in this period was 12,700,000, and the over-all rejection rate was about 28 percent.

But a rejection rate of 28 percent cannot be dismissed. Isn't the rejection of 3,600,000 men enough to make us disgusted with our scheme of medical services?

According to the Federal Security Administration, the answer is yes. According to the official propaganda which you and I are paying for, one-half to two-thirds of all draft rejections could have been avoided by adequate medical care and are, therefore, evidence of widespread medical neglect.

Again, what are the facts?

The governmental officials who have repeatedly made these statements, who have placed these words in the mouths of many witnesses coming before the Senate Committee on Education and Labor, are not physicians. They lack the technical qualifications which would permit them to make any statement whatsoever regarding the relation of draft rejections to medical care. So far the Federal Security Administration has not been able to produce the statement of a single physician to support their guesstimate of draft rejections preventable by medical care.

Dr. Leonard Rowntree, one-time medical director of the Selective Service System, ventured the opinion that draft rejections for remediable defects constituted about 15 percent of all rejections. In an independent analysis of the data, I concluded that no more than 20 percent of all rejections could have been influenced by medical care; that is, approximately 6 percent of all men examined.

If Dr. Rowntree was correct, if I was correct, why were so many men rejected? We must remember that the draft boards were not choosing men to play tiddlywinks. The Selective Service System had the task of selecting men for combat, men who could be expected to withstand the terrific strains of modern warfare, men who could adapt themselves to the strictly regimented life in the armed forces. The mobilization orders were explicit in defining the type of man wanted. Acting under these specific directions, the selective-service physicians kept one eye on combat requirements and one eye on the lookout for defects which, though not a great handicap, might be grounds for future claims in the form of pensions or free medical service.

Official bulletins of the Selective Service System have repeatedly emphasized these facts. These bulletins stress the point that an overwhelming majority of the men examined "had been drawn from useful occupation in civil life which they had followed without apparent handicap." Let us listen to the exact words of the officials of the Selective Service System:

"There seems to be little doubt that most of the registrants being classed as available for limited military service and a substantial portion of the registrants being classed as disqualified for any military service in the United States Army possess health conditions which would be acceptable for military duty in any army in continental Europe.

"In addition to the nondisqualifying defects, a large proportion of the disqualifying defects were minor insofar as health conditions are concerned. The loss of an index and middle finger, the loss of a great toe, or the fact that a registrant is less than 60 inches in height is sufficient cause for rejection, but such conditions do not indicate that the registrant is in poor health."

These warnings of the Selective Service System were not hidden in any secret archives. They were prominently placed in the very bulletins which the Federal Security Administration was using to scare our people. Indeed, in view of the clear warnings of the officials of the Selective Service System, there is no excuse for anyone, with or without technical training, to misinterpret the draft statistics. The members of the Federal Security Administration did not heed these warnings.

They did not heed the unequivocal statement of Col William Menninger, psychiatric consultant of the Army. With reference to the great number of rejections for psychiatric reasons, Colonel Menninger warned against the misuse of these statistics:

"It has been no surprise to the psychiatrists that this segment of the population has been uncovered, and is no special cause for alarm as to the mental health of the Nation * * *. It concerns our family life and educational system. It is intimately linked with the prevailing attitude of the public toward their specific service in the Army. To many men, the security of their homes and their friends and their jobs far outweigh their belief in their importance for and their need by the armed forces. The rejection of this group of men for acceptance to the Army has been widely misunderstood and misinterpreted. The Army, like a football team, needs the best. * * * The fact that a man may be a regular worker, a community asset, is no indication that he can fit into the Army or be an asset to the Army."

The lay members of the Federal Security Administration chose to ignore these warnings by competent medical authorities. These public officials, posing as expert and unbiased advisers to the Congress, persisted in misusing the draft statistics in their advocacy of national compulsory health insurance. For many years they have supplied most of the drive for the enactment of legislation which would affect intimately every person in this country and would subject the professional activities of every doctor to regulations laid down by the Federal Government.

The drive has been successful. Under the terms of a bill now before Congress the Federal agency for the supervision and direction of medical care would be the Federal Security Administration. In other words, the very men who are "advising" the Congress are now, and have been for years, engaged in a vigorous campaign to enact legislation which would vastly increase their own powers, their own influence and personal prestige. Against this background, we cannot assume that these men have been free of bias or that they have been acting as impartial scholars.

It is unfortunate that the average person, who is so well informed about the technique of Fritz Crisler's backfield, the latest development in automatic transmission, or the call prices of preferred stocks, knows so little about health.

How can we measure the health of our community, of our Nation? Granting that the draft rejection figures are almost worthless in this regard, can't we put the Selective Service statistics to some use? Yes, we can use these statistics in a limited way and with proper precautions.

Complete records were kept of Selective Service examinations. These included the findings not only of the usual physical examination, but also the results of the X-ray examinations and the blood and urine examinations which were done on every man. Some of the men who were accepted for military service had one or more minor defects. These, too, were recorded. Many of the men who were rejected revealed not only the major defect for which they were disqualified, but one or more additional defects. Thus the original data of the Selective Service include records of every defect, disqualifying or not, uncovered by these physical examinations.

WHAT ARE OUR DEFECTS

Of what significance are these defects? Are they a measure of our health? Can they be used as a measure of the adequacy of our medical care?

In the first place many of the recorded defects have no direct relation to health or medical care, but are directly related to our educational facilities. Examples are "educational deficiency," "failure to meet minimum intelligence requirements", and the largest portion of those individuals designated as "mentally deficient." Of the remainder of recorded defects, most are structural abnormalities rather than diseased states.

For example, "enlarged tonsils," "absence of one testicle" (congenital) and "flat feet" were recorded for many individuals although these structural abnormalities had not handicapped them in civilian life. There is the famous incident of the young man who was returned to civilian life because of flat feet and who immediately resumed his career in professional football.

It is a bit of irony that many of the recorded defects were not the result of medical neglect, but the direct result of medical treatment. All of the amputations are in this category. Many of them were done as lifesaving measures after serious injuries. Surgical perforations of the middle ear also are in this category. Before sulfa drugs, surgical drainage of the middle ear was frequently necessary.

But still more important is the paradox that the very existence of many defects is evidence of our good health. Before the days of insulin a diabetic child would not live long enough to be recorded as a defect by the draft board. Many of the men listed as having tuberculosis would have long since checked in with the undertaker instead of the draft board were it not for modern medical diagnosis and treatment. Many with rheumatic heart disease would never have reached voting age without the supervision of skilled physicians.

Until 2 or 3 years ago children with the more severe kinds of congenital heart disease were doomed to a sedentary existence confined to the bed or wheel chair. Their faces were blue. They could not walk across the room without great effort. About one-half of these children died before puberty. With the miracle of modern chest surgery, these children need not die. Although the surgeon cannot make combat soldiers out of them, he can convert them from bed-ridden invalids into useful and happy citizens. When these children become of age, our draft boards will be able to record even more defects. Shall we operate and save these children? Or shall we let them die off so that our Selective Service statistics will look better?

Is a corpse healthier than a young man disqualified for military service because of diabetes?

No indeed, we cannot use the Selective Service statistics as a guide to the health of our community. They can be of limited use, only if we integrate them with other, more important data. To measure the health of a community, we must note the frequency of contagious diseases, particularly those which are so closely related to public hygiene, such as typhoid fever and dysentery. We must place proper emphasis on the infant and maternal mortality rates, and the morbidity and mortality rates from other diseases. We must make an estimate of the life expectancy of our community. Finally, we must give proper weight to the birth rate. No community can be considered a healthy one if the adult population is able to live but unable to reproduce itself.

Even when all this has been done, valid conclusions can be drawn only by experts because there are so many pitfalls. For example, as a nation or a community grows more and more healthy, the crude death rate (number of persons per 1,000 population dying from all causes) goes down. Eventually, however, a point is reached where continued improvement in the health of the community results in an increase in the crude death rate. In fact, because of our favored position in health matters, the United States, along with the Scandinavian countries and a few others, have already reached this turning point.

POPULATION IS GROWING OLDER

As we learn to control the contagious diseases and the decimating illnesses of childhood, more and more individuals survive to be enumerated in the older age groups. Gradually the composition of the entire population changes. A young community gradually becomes a much older one. Unfortunately we have not learned to prevent high blood pressure, heart disease, or cancer. We have not learned to prolong the life of man indefinitely. Despite the advances of medicine, man is still mortal, and the death rate for old men is much higher than that for younger men. Thus a progressive and healthy nation may show a rising death rate. Its progress in health would then be reflected in an increase of life expectancy.

Because of the age and several other equally important factors, it is not easy to compare the health of one nation with that of another. Errors are easily made and statistics can be tortured into a frame to support any particular kind of propaganda. It is still more difficult to evaluate the precise role of medical services in the health of a community. In recent years we have heard much about those poor, sparsely settled counties without general hospitals and without an adequate number of physicians. So far as I am aware, there is today no satisfactory basis on which to calculate how many physicians per thousand population is an adequate number.

During the war more than one-third of our physicians volunteered for service with the armed forces. Thus, there remained for the civilian population not more than two-thirds of its ordinary supply of doctors. In spite of this marked reduction in available medical services, maternal mortality was cut in half between 1940 and 1945. During this same period, infant mortality decreased by about 20 percent.

This does not mean that we would have been still better off if all of our doctors had gone to war. It does mean that our health is not determined solely by the number of doctors and the number of hospitals. A striking illustration of this fact is the prevalence of venereal disease in the armed forces. In the Army and Navy there was 1 doctor for every 250 men which is equivalent to 2 to 3 times the number of doctors in our largest cities. Their services were not only available day and night without cost but special VD control officers pleaded with the men to use the facilities. These special officers conducted vigorous educational campaigns to instruct the men in the use of prophylactic measures. In every town of any size special prophylactic stations were established and kept open all night. At these stations men who had ignored the warnings of the medical officers could obtain early prophylactic treatment after exposure.

In brief, a soldier or sailor could avoid venereal infection or obtain treatment for it at no cost at all, but he did not get venereal disease for nothing. It took money to go out and pick up an infection. Nevertheless, venereal disease was rampant in every military establishment at home and abroad, and just as with civilians the rate was astronomically higher among colored troops. Indeed, despite the elaborate provisions for medical services in the armed forces, the ratio of the VD rate in colored servicemen to the rate in the white servicemen was precisely the same as it was in the civilians who were examined by the draft boards.

To be sure, medical care is an important element in community health, but it is not the only element, and it frequently is not the most important element. At one time in the Great Lakes region the women were very self-conscious about their big necks. The big necks were not a distinct heredity trait, but were due to the low iodine content of the water and of the vegetables grown in that area. The lack of iodine produced goiters not only in the women of the Great Lakes, but also in the dogs, the frogs, and the fishes. With no significant change in the number of doctors, and certainly no change in the medical services available to the dogs, simple goiter has practically disappeared in both the human and canine population. This has been accomplished by the simple means of adding a small amount of iodine to the table salt.

HOUSING AFFECTS HEALTH

In your own community, geography may not play such an important role. The local housing situation may be much more important, particularly with respect to contagious diseases since they thrive in undernourished individuals jammed into overcrowded and inadequate dwellings.

And, speaking of housing facilities, we cannot overlook the outhouse, which has contributed so much to our humor but also to the spread of disease. There are large areas in this country where the installation of modern plumbing would do more good than the importation of a whole battery of medical specialists. There are equally large areas where the introduction of a safe water and milk supply would yield much larger health dividends than an increase in the capital investment of local hospital facilities.

We cannot do without doctors and hospitals—yet. Even if every individual in every community took full advantage of preventive and public health measures, we would still be confronted with the victims of those degenerative diseases for which we have no preventive measures. But, to a large extent, the number of persons forced to seek medical attention because of illness is a measure of our failure to utilize fully our present knowledge. The quaint belief in some southern cities that summer diarrhea is caused by hot weather cannot be accepted as a bit of folklore. The unpalatable fact is that summer diarrhea, like typhoid and other related diseases, is evidence that the people are eating or drinking contaminated food, water, or milk.

Doctors and public health officials can watch over your drinking water and your milk supply. They can inspect your public eating places and warn you of any dangers in swimming pools and beaches. They can advise you in the control of contagious diseases and industrial hazards. But doctors and public health officers do not have the power of legislation on health matters. They alone cannot enforce existing legislation. These functions are properly in the hands of the public and its representatives. Even so, legislation and coercion are not the answer.

HEALTH NEED EDUCATION

We cannot legislate good health into being any more than we could create temperance by the passage of the Volstead Act. Good health is not a commodity which the Government can deliver to you in a neat package. It cannot be administered to you out of the doctor's little bag. The attainment of good health requires the active and intelligent participation of every member of the community. Given all the paraphernalia of modern medical science, the well-being of the community will not improve unless the people are sufficiently well educated to take advantage of what is offered. In many sections of the country the chief barrier to improved health is ignorance.

What can you do to improve the health of our Nation? As a citizen you can give your whole-hearted support to any effort in your civic organizations to assess the health of your community and to single out and define your most urgent needs. As an individual you can begin your health crusade at home.

It is not enough to protect your family against infection and serious injury. Much of present-day illness is due to emotional conflict. To prevent these functional diseases, and more serious mental diseases, there is nothing so important as the character of the home. Your children should have the emotional security that only love and a harmonious family life can give.

Finally, for your personal well-being, seek the advice of your doctor periodically for preventive services. Don't wait until you are acutely ill. The frequency of your regular examinations will be determined not only by your physical condition, but also by your age, and the medical history of your parents and grandparents. Let your doctor be the judge. No man or woman can hope to go through life without a few aches and pains.

In a vast majority of instances, these minor protests are of no more significance than the rattle of a loose tool kit in the trunk compartment of your auto. But some kinds of distress, even though mild, have frightening potentials. Your doctor can teach you to spot the warning signals important in your particular case. You can then disregard the trivia and avoid the status of a hypochondriac who sees a cancer in ever wart.

Not everyone can afford to play tennis after his sixtieth birthday. For some individuals a jigger of whisky three times a day is necessary for survival. For others it is poison. Let your doctor review your mode of life, your diet, your habits. He will probably be able to make some worth-while suggestions which will prolong your useful life.

Even with our present level of national income there are undoubtedly many people who cannot shoulder the entire burden of a major illness. But the distribution of medical care in this country is not dominated by the economic factor. Take a look at your own community. The poor are not being neglected. Admittedly, our present methods for the distribution of medical services are far from ideal. We should continue to strive for something better. It is heartening that more than 30,000,000 of our people now have the benefit of Blue Cross hospitalization insurance. Another 20,000,000 have some sort of commercial coverage. In several parts of the country various experiments with prepaid medical care are on trial. From the experience of these enterprises we shall obtain a valuable store of practical knowledge to guide us in our quest for better health.

In the meanwhile there is no need for hysterics. We can well afford to resist any rash political action which would sabotage a system that has enabled us to become one of the healthiest nations in the world. Certainly the health of our country is not in such desperate state that we must rush to surrender complete control of our medical care into the hands of an all-powerful Federal agency—an agency whose members are responsible for the propaganda to convince you that we are a nation of cripples and weaklings.

Dr. SHEARON. I think that brings to an end most of the material that I had to give, and I want to thank you for this opportunity to be heard. I had something to say about the attacks that have been made on me, but I do not wish to use this forum for that purpose, and I understand that Senator Murray is planning a final attack on me.

I think a letter said the other day he would attack my credibility as a witness. At that time I should like to insert a very brief statement in answer to what may be said, and also in answer to what has already been said in the record, but I do not want to discuss those personal affairs here.

My interest is in this legislation. On the other hand, some very untrue things have been said about me and I would like to insert a very short statement to that effect, and I would like further to suggest one other thing.

I would further like to suggest this, because my relationships with Senator Murray, my personal relationships with him, have been very pleasant. We have talked together several times and I have never seen any evidence of this personal animosity that has come out in certain documents that have been introduced, and I should like to be quite sure when this last statement that is to be filed by Senator Murray comes in that he really has read it and it is his wish that the attack be made on me and not the wish of some of his staff.

Senator DONNELL. Doctor, I don't think we would have any authority. We might have technical authority, but I think there would be some reluctance on the part of the committee to interrogate the Senator as to whether or not it is his own production. If he places it in the record, I think he would be vouching for it.

Dr. SHEARON. Well, you know he did place one statement in the record and he hadn't read it, and he did withdraw it when I called it to his attention.

Senator DONNELL. I think he would realize that whatever he puts in the record would be regarded as if it were his; that he would be vouching for it. I don't think that we could very well interrogate the Senator and I don't know whether we feel it would be appropriate to interrogate him as to the authoriship of what he puts in because he would vouch that whatever he states is his own production.

Now, Doctor, I want to thank you for your testimony and you have rendered, in my judgment, an invaluable service to this committee. I personally appreciate, and I am quite sure those of the committee who have had the opportunity to observe your work appreciate the very fine assistance and ability and tremendous fund of information which has been evidenced by the work that you have rendered and by the testimony which you have given, and I can assure you of our appreciation for what you have done for the committee and for myself, as one of the members of it in connection with this whole problem.

Now is there anything else, Doctor, that you have in mind to present?

Dr. SHEARON. Would it be proper if in going over my material—I mean there is a wealth of material here. It is enormous, as you can see—if I could within the next few days, say by the 5th of June, submit anything further for the chronological record or not?

Senator DONNELL. I think that will be all right. I will ask you to use your best judgment not to place too great volumes in the record.

Dr. SHEARON. No. There is such a volume of material. There was one thing I wanted to read into the record, just a sentence from this ILO report which was put out in 1944 and which I have referred to frequently, Social Security Principles and Problems Arising Out of the War. It says:

> No account is taken of plans, however great their intrinsic interest, which are sponsored by private persons or groups.

I mentioned this the other day, but I could not find the sentence at that time. The ILO is interested only in government plans, and I think that that is a very important thing to realize, so that no matter what intrinsic interest of private groups is, if it is not a government thing, the ILO is not interested in it, and yet we are keying all of this compulsory health insurance legislation to the ILO principles, and in section 702 of the Social Security Act it is important to note that they say methods of improving the social security of the people through social insurance as though there were no other way in which the Social Security Administration can study the methods of improving the economic security of the people as a whole except through social insurance. There are other ways of doing things.

Senator DONNELL. At this point in the record I should like to refer to an article in the Christian Science Monitor of Wednesday, May 26, 1948, which is entitled "Brookings Institution Piles Up Points Against State Medicine." I shall not read all of it into the record. It contains a summary of conclusions of a study of the Brookings Institution, but there are two or three paragraphs that I should like to read into the record at this time as to the investigation made by the Brookings Institution.

> The investigation was undertaken at the request of Senator H. Alexander Smith (Republican) of New Jersey, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare; Senator Smith's committee is holding hearings on sickness insurance bills.
>
> The Brookings Institution, which is devoted to public service through research and training in the social sciences, is an impartial organization, outstanding in its field. It frequently receives requests from congressional committees for memoranda or consultations on economic and administrative problems.
>
> Its 270-page book entitled "The Issue of Compulsory Health Insurance" was written by its vice president, Lewis Meriam, and Dr. George W. Bachman. Brookings published a 900-page volume on social security by Mr. Meriam 2 years ago, and he has had extensive experience in connection with the statistical and administrative aspects of health problems. Dr. Bachman was formerly on the faculties of Chicago, Johns Hopkins, and Columbia Universities, and organized and directed for 11 years the School of Tropical Medicine in Puerto Rico.

Well now, Doctor, is there anything further that you have to offer?

Dr. SHEARON. No, thank you.

Senator DONNELL. I appreciate your testimony, as I indicated.

(Dr. Shearon submitted the following brief:)

TESTIMONY OF MARJORIE SHEARON, PH. D., BEFORE THE HEALTH SUBCOMMITTEE OF THE SENATE COMMITTEE ON LABOR AND PUBLIC WELFARE AT THE HEARINGS ON S. 545 AND S. 1320

QUALIFICATIONS OF WITNESS

I have been asked by this subcommittee to appear as the final witness at these hearings. I appreciate the opportunity and am aware of the responsibility which devolves upon me.

For the record I may state that I am director of the Shearon Medical Legislative Service, author and editor of American Medicine and the Political Scene (a weekly analytical news release), writer, lecturer, and legislative consultant. My academic training was in scientific research in the biological sciences. I received my Ph. D. degree in science at Columbia University in 1916. For 10 years I was engaged in research in pure science and in college and university teaching. I have published extensively in scientific journals and am a past fellow of three national scientific societies. For the past 15 years I have been engaged in public administration, Federal, State, and local. My recent experience includes nearly a decade in the executive branch of the Federal Government, 5 years in the Bureau of Research and Statistics of the Social Security Administration, and 4 years with the United States Public Health Service. From February 1945 to March 1947 I was research analyst first to the minority conference and later to the majority conference of the Senate. Last year I served for a time as health consultant to the Senate Committee on Labor and Public Welfare, later becoming a part-time consultant to Senator Robert A. Taft, chairman of that committee. Presently I am operating my own business and am not in the pay of any individual or organization. I have no political, business, or professional ties, nor am I a member of any political party. As a legislative consultant, I appear in the public interest expressing my own views but not speaking for any group or special interest.

My experience in the field of health and medical legislation and programs covers a period of about 15 years. It includes work in a clinic for mental defectives, the development of an appraisal form for measuring community activities for mental defectives, and a year spent in New York State studying the history of public health organization in this country. I have had experience with administration of medical care programs for the needy in New York City and in the

Middle West. For the better part of 8 out of the past 10 years I have worked on health and medical legislation and on the development of plans for a national health program.

While at the Social Security Board from 1936 to 1941, my primary interest was in the field of old-age security. I prepared the economic brief entitled "Economic Insecurity in Old Age," which the then Attorney General, Robert A. Jackson, used in defending titles II and VIII of the Social Security Act before the Supreme Court and I also furnished the major portion of the material which he used in defending titles III and IX. On completing that task in 1937, I was assigned to the staff of Isidore Sydney Falk, then Chief of Health Studies in the Bureau of Research and Statistics, of the Social Security Board, where I remained for 3½ years. I continued to work in the field of my primary interest, namely, the economic status of the aged, but devoted possibly a year and one-half to medical and disability legislation and the study of compulsory sickness insurance administration. I worked on research documents for the National Health Conference called by President Roosevelt in 1938, and on the medical care provisions of the grants-in-aid title of the 1939 Wagner bill drafted by Mr. Falk and his staff. I spent the entire year of 1940 on a report on the economic status of the aged, prepared at the request of the Social Security Board for the use of Congress and subsequently used by the Committee on Education and Labor in 1941. On completing that report early in 1941 I sought, and obtained, a transfer to the Public Health Service where I expected to continue my work on problems of the aged with Dr. Edward J. Stieglitz. His resignation at the very moment of my transfer resulted in my being assigned to the Division of Public Health Methods of which Mr. George St. John Perrott is chief.

That Division deals with statistics, health information, and health legislation. Thus I was again brought into the health field and had occasion to know a great deal about the drafting of the 1943 Wagner-Murray-Dingell bill and the preparations for the 1945 Wagner-Murray-Dingell bills. During 1944 I was the only full-time employee in the Public Health Service working on postwar programs for national health. At the request of Surgeon General Thomas Parran I prepared the Ten-Year Postwar Program of the Public Health Service which covers all phases of a national health program, including a description of each component program, the annual and 10-year costs, and the personnel required. That program, approved late in 1944 by the Surgeon General of the Public Health Service, by his chiefs of staff, and by Paul V. McNutt, then Administrator of the Federal Security Agency, was referred to the Bureau of the Budget which likewise expressed approval.

I have attended practically all hearings dealing with compulsory sickness insurance and related legislation since 1938. In addition, I have traveled extensively throughout the United States and the islands of Hawaii, with a view to learning first hand something about the social and economic problems with which I have been working. I trust that my experience in connection with the drafting of the bills now before this subcommittee and of predecessor bills may be of some service to you.

THE PROBLEM STATED

This subcommittee has now nearly completed the hearings on two bills, S. 545 and S. 1320, which deal with an extremely controversial issue. Dozens of witnesses have been heard. Reams of statistics and volumes of statements have been presented for your consideration. You have been urged to act quickly, to do something before the Nation collapses from the disabling, often fatal, diseases that ravage our otherwise fair land. With equal ardor and persuasiveness you have been assured that our national health is remarkably good, that the United Sttes compares favorably with the other nations of the world. The assertions made by various witnesses cannot all be true. Nor could Congress, if it would, comply with all the conflicting proposals for action which have been made by proponents and opponents of the two bills now under discussion.

I shall endeavor to state briefly the nature of the national health problem toward which these two bills (S. 545 and S. 1320) are directed and the philosophy back of the proposals. Second, I shall give a few illustrations of the implications of the legislation. Third, I shall make some recommendations for your consideration in deciding what action should be taken. Finally, I shall give a résumé of the historical development of this national health legislation.

The problem you are considering has been receiving more and more attention each year since President Roosevelt called the National Health Conference in 1938 and Senator Wagner introduced his first national health bill the following year. There has been increasing agitation for some sort of legislation that would provide Federal funds for governmental intervention (State, or Federal, or both), in the distribution of medical, hospital, and related health services.

The first question which the members of this subcommittee will have to decide is whether or not they are convinced that a serious health problem of national proportions exists. As impartial judges of the evidence submitted, you will have the responsibility of deciding whether (1) the health of our people is at a low ebb; (2) medical, hospital, and related services are inequitably distributed; and (3) health and medical resources are unavailable to the majority of the population. If you are convinced that such is the case it will be further necessary to decide whether the several conditions are so widespread as to constitute a national emergency of sufficient proportions to justify invoking the taxing power and the resources of the Federal Government.

Statistics and reports have been presented to convince you that our unmet health needs are Nation-wide, that States and localities unaided cannot cope with the problem, and that voluntary action by the people on their own behalf is futile and ineffectual. Part of the problem, it is said, is that health personnel—physicians, dentists, nurses, etc.—and health facilities—hospitals, health centers, and research centers—are poorly distributed. The claim is made that cities are too abundantly supplied with health personnel and facilities while rural areas are undersupplied. You have been told repeatedly the draft rejections indicate that our national health is in a woeful state and that the health of our children has been neglected. Correction of these deficiencies, it is claimed, must be undertaken by the Federal Government.

On the assumption that Federal intervention is necessary in meeting the situation described, two types of legislation have been proposed. One (S. 545) is modest in scope. It would give financial assistance to the States through grants-in-aid distributed according to an objective formula based on the needs and fiscal capacities of the several States. Administration would be on a Federal-State basis, the Federal Government setting standards, giving technical advice, and passing on State plans and programs. The second type of legislation (S. 1320) calls for the creation of a system of medical care insurance as part of a national scheme of compulsory social security. It involves a taxation program not incorporated in the bill, it promises a wide variety of services for the entire population, and it inevitably raises a multitude of questions relating to the desirability of Nation-wide compulsory sickness insurance, or as it is called, "medical care insurance."

Briefly then, this subcommittee must decide three things at the start (1) whether there is a national-health problem calling for Federal intervention, (2) whether any Federal legislation—one of these bills or some other bill—is called for at this time, and (3) assuming that some legislative action is desirable, which type of legislation is best suited to American needs.

These are questions not to be answered lightly. Your decisions will have far-reaching effects. They will concern not only the health of the people, but our entire way of life, and, I doubt not, the very form of government under which we live. Similar questions have cropped up in most of the countries of the modern world. Legislative bodies in Europe, Asia, South America, and elsewhere have deliberated even as you are deliberating. For the most part they have chosen to enact laws of the same general pattern as that which is embodied in S. 1320. That is, they have chosen to adopt systems of national compulsory social insurance which included both medical benefits and cash benefits for sickness and permanent disability.

In reaching your decisions you will undoubtedly realize that the evidence presented has been far from objective. Conclusions and recommendations have been conflicting. The reliability of some of the reports presented by Federal officials and by nongovernmental witnesses has been questioned by responsible authorities. The creditability of some witnesses and of some interpretations has been attacked. Some of the testimony has been of little value because the witnesses obviously were unfamiliar with the content of the bills in question, or were totally unaware of their administrative implications. Other witnesses were both unfamiliar with content and unaware of implications. Perhaps you may conclude that after all these hearings you still lack the basic knowledge needed to form an impartial judgment. You may decide you need more information or, let us say, better information; more light, less special pleading.

Let us now proceed to the philosophy and implications of the two bills.

THE PHILOSOPHY AND IMPLICATIONS OF S. 545

S. 545 makes use of the time-honored Federal grants-in-aid technique to assist the States in developing their own health programs. It amends the Public Health Service Act by adding some new sections and two new titles and by proposing a reorganization plan for Federal health and medical activities. Of the two new titles one (title VII) relates to medical care for persons and families with low incomes, the other relates to dental inspection and dental care for school children and for persons with low incomes. The provision which has attracted the most attention is that which provides $200,000,000 a year for 5 years for medical-care grants to the States. In this respect the bill takes the Federal Government into a new field of activity, namely, the provision of medical care for a certain portion of the population variously estimated at from 20 to 25 percent of the total.

For the purpose of sharpening the legislative issues presented by S. 545 and S. 1320, I shall concentrate on the medical care provisions of the two bills because these are the most controversial, the most difficult to decide upon. S. 545 is, shall we say, a less terrifying bill than S. 1320. Indeed, it is so mild in appearance that its opponents have condemned it as inadequate and as a mere charity measure.

However, I believe that this subcommittee and the Congress as a whole might wish to ponder not so much the present mildness of the bill and its present preoccupation with persons of low income, but rather the broad implications of the utilization of general Federal revenues to pay part of the medical care bills of a loosely defined segment of the population. This segment is sometimes called the medically needy. The bill nowhere defines who are persons in the low-income group. That decision is left to the States. Indeed, it would probably devolve on local welfare workers or health officers to make individual, subjective decisions as to who would be entitled to the promised aid. Congress did the same thing when it passed the Social Security Act without defining who were the needy persons entitled to old-age assistance and other aid. It is not difficult to see that administratively it might be difficult to decide who is medically needy. Perhaps nearly everyone in the course of a lifetime is medically needy at least once. Even a person with a substantial income might qualify for aid under S. 545 if he or a member of his family were the victim of one of the more expensive chronic ailments such as cancer, diabetes, or infantile paralysis, or if the costs of an expensive operation had to be met.

Thus it must be evident that S. 545 might be opening the door to almost universal Federal aid from general revenues to pay the costs of medical care, hospitalization, and related services. True, that would not be the intent of the bill, and at the start funds would be limited to $200,000,000 a year. Congress would hold the purse strings. But pressure from administrative agencies, from nongovernmental vested interests, and even from members of Congress seeking popular approval and political advancement might ultimately carry us a long way toward Federal control of medicine and development of a too powerful bureaucracy. I do not say that such would be the case. But it is a possibility that should be weighed by this subcommittee. Similar expansion has occurred, say, in the programs of the Children's Bureau with the result that there is now before Congress a bill (S. 1714) that would nationalize medicine for all mothers during the maternity period and for all children up to the age of 18 years. That bill calls for grants-in-aid but it would be meshed into a national compulsory insurance law when and if one were enacted.

The more I study the course of legislation and of Federal operating programs the more I am impressed by the fact that great changes in our way of life are brought about by laws which begin modestly. They appear to be in the public interest. They do not involve vast sums or large administrative staffs. But after a few years, appropriations and staffs grow to amazing proportions. Budget requirements never decline. Staffs dig in and seek to perpetuate themselves. A modest, innocuous Federal program, once thrown into the bureaucratic hopper, is certain to expand unpredictably and perhaps deleteriously. Therefore, in embarking on a whole new field of Federal action, namely, the field of personal health services for individuals, it would be well to look ahead a decade to see how such a program as the one proposed would be likely to develop.

THE PHILOSOPHY AND IMPLICATIONS OF S. 1320

Creation of comprehensive system of national social security.—When we turn to S. 1320, we find an entirely different type of bill in the main, although it, too, makes use of grants-in-aid for personal health services for some segments of the population. But the distinctive feature of S. 1320 is that it calls for establishment of a Federal system of compulsory medical-care insurance as part of a comprehensive scheme of national social security. The significance of the bill cannot be appreciated if it is viewed out of its context of omnibus compulsion for the entire population. This subcommittee is thus brought face to face with the multitudinous questions surrounding the entire social-security program.

For more than a decade now we have been living under the Social Security Act as passed in 1935 and repeatedly amended. I believe this law is the most important piece of domestic legislation that has been enacted by the Congress of the United States up to this time. It is significant not so much for what it does initially as for the long-range effect it will surely have unless Congress blocks further expansion.

Turning to S. 1320, we see that medical-care insurance is to be made part of a comprehensive national social-security program. The blueprint for the over-all social-security plan is best seen in the 1945 W-M-D bill, S. 1050, which furnishes the total legislative plan for the several cash benefits programs and for certain free services, such as medical care and hospitalization. That bill was referred to the Finance Committee and there shelved, but it is worthy of the most careful study by this committee. When it was introduced I prepared a digest of the bill for the minority conference and I now wish to incorporate the digest at this point (exhibit A). In 1945 the administration planned and hoped that the whole legislative proposal could be enacted at one time. Since that did not happen, the legislative strategy was changed to bring in different parts of the program piecemeal. However, in deciding whether one part of the scheme is desirable, one must view the whole scheme. In brief it is this:

There would be set up in the United States a National Social Insurance System to be administered by the Federal Security Agency. A national social-insurance trust fund would be created on the books of the Treasury of the United States. The Federal Security Agency, instead of the Bureau of Internal Revenue, would collect all social-security taxes or designate the collecting agency.

The significance of S. 1320, therefore, does not come fully to view until one sees it in this comprehensive setting. Medical-care insurance would be one part of the National Social Insurance System. Legally, administratively, and financially it would be linked to all the other programs in that System. It would be closely related to the two cash-benefits programs, one for temporary disability, the other for permanent disability.

In deciding whether you think this type of legislation is desirable for the people of the United States it may help you to visualize how it would operate. Let us suppose that Congress has enacted S. 1320 and the other bills to create a National Social Insurance System and that the executive branch of the Government is now ready to begin administration. New social-security taxes would be imposed immediately for the purpose of building up reserves in the several trust accounts in the Federal Treasury. These taxes would be modest at the start in order not to alarm the Congress or create too much popular resistance. within a few years they would rise probably to 6 percent on employees and 6 percent on employers on the first $4,800 of income. That is the amount which Arthur J. Altmeyer, Commissioner of Social Security, has just proposed to the advisory council of the Finance Committee (in a statement presented to the council on December 4, 1947, exhibit B). During the first year of operations benefits would not be given, but staff would be hired and rules and regulations written.

Rules and regulations.—In this connection I would point out that there has been no discussion before this subcommittee of the rules and regulations of compulsory sickness insurance, yet they are of infinitely more importance than the provisions of the basic statute. Whereas the Members of Congress enact the original law, thenceforth it is the Federal officials in the executive departments who write and enforce the rules and regulations which have the force of law. The number of such rules and regulations is staggering. So is their complexity. By the time social insurance had been in operation 40 years in Germany the number of laws, ordinances, and interpretations was so voluminous that a prominent expert in that country stated, "There is no longer a single specialist in Germany who knows even superficially the principal features of social insurance" (1). Yet fewer than 40,000,000 persons were involved as against our 143,000,000. During the 1920's "So many changes in the [German] laws on social insurance were made that the pertinent commentaries were no longer published in book form but in catalog form, so that any entry could quickly be replaced by another. Alterations were so numerous that the comprehensive laws which were enacted in 1911 had to be completely reenacted 13 and 14 years later" (2).

In great Britain, where only 40 percent of the population—that is, approximately 20,000,000 workers—was covered by national health insurance, the number of rules and regulations reached the staggering total of 2,000 within three decades. It required a volume of nearly 1,300 pages in length to cover the rules and regulations, the health-insurance laws and amendments thereto, and the interpretations of these legislative, regulative, and interpretative pronouncements. If such a volume of regulatory interference with the lives of the people was necessary in the small area of the British Kingdom where the population is reasonably homogeneous and the geographic conditions do not show great extremes, then I submit that the volume of regulations for a population og $143,000,000 in a country with the geographic variety and the social and economic differences found in the United States would be astounding. Physicians, dentists, nurses, hospitals, and patients would eventually be overwhelmed by these compulsive rules, regulations, and laws. This is what is meant by compulsion and by unwarranted regulative interference with the daily lives of every person in the United States (exhibit C). This is the sort of thing that leads to the police state. This is the aspect of national compulsory social insurance which is not discussed by or with legislative bodies before national laws in this field are enacted. The people and the legislators are kept in the dark about the way in which such laws operate.

You may well ask if it would not be possible to avoid such complex administration. My reply is that I am convinced such avoidance is impossible. National systems of compulsory insurance have been in operation for many years in many countries. Ingenuity has been taxed; experience has been accumulated. Administration of all social-insurance programs and of compulsory sickness insurance in particular is cumbersome, confusing, compulsive. If there had been any simple way to administer social insurance for small population units of from 1,000,000 to 40,000,000 persons, that way would surely have been discovered in 65 years. There is not the slightest hope that a simple or bearable method of administration could be developed for a population of 143,000,000 persons.

Twenty years ago the International Labor Organization published an exhaustive volume on the laws of compulsory sickness insurance then in force throughout the world and set forth the principles to be followed in writing rules and regulations. Subsequently, a special volume was published entitled "Economical Administration of Medical Benefits." The whole philosophy underlying compulsory sickness insurance is one of regulative control. There are rules for patients, for physicians, for nurses, pharmacists, hospitals, and so forth. Primary emphasis is placed on protection of the insurance funds, not of the patient. Everyone involved in the system—and under the proposals now before Congress, that would be everyone in the United States—would be compelled to be subservient to the Federal officials who would police the system or to the local representatives of governmental authority who in turn would be nothing more than remotely controlled proxies acting as "peripheral contacts" for the Federal Government.

Without my going into a lengthy discussion of the question of administration, I believe you will have no difficulty in picturing what would happen if such a system were set up in the United States. The whole country would have to be divided into administrative districts, similar perhaps to present school districts or police precincts. Whether the system were decentralized at the start, as is now proposed, or were ultimately operated wholly from Washington, as a result of pressure for centralization, the fact remains that some manner would have to be found to supervise a Federal program that would cover 143,000,000 persons. There would have to be thousands of administrative offices. Thus it presently requires over 3,000 employment offices for the administration of the United States Employment Service for a few million unemployed persons. When it came to setting up the offices for administration of compulsory sickness insurance, 3,000 offices would be a mere drop in the bucket. There are over 175,000 governmental units in the United States. Most of them would have to have some insurance staff.

Policing the sickness-insurance system.—In Germany there was a medical referee for every 25,000 of population. In view of the complexity of the benefits which are being proposed in S. 1320, I surmise a far larger number of medical and other referees would be required. Indeed, the number of investigative and other administrative personnel working either directly out of Washington or under remote control therefrom which would be required to police the sickness-insurance system is truly staggering. I cannot help thinking that such a corps of referees, inspectors, and the like, spreading out through our country to every village and town, would be a menace the like of which we have never known. Not a family, not an individual would be safe from the eternal police surveillance of the Federal sickness-insurance administrative machine.

When I speak of policing the sickness-insurance system, I refer to the administrative procedures that would be necessary to enforce the Federal rules and regulations and to insure that the Federal insurance funds were spent economically. A count would have to be kept of the number and cost of all prescriptions issued by all physicians. Whether this count would be kept by Federal officials or by local governmental officials who would report quarterly to the Federal Government you can readily see that the task would be a tremendously costly one. Similarly, there would have to be pricing bureaus to decide what prices should be chaged by more than 80,000 pharmacists throughout the United States for the prescriptions for free medicines. Every druggist would have to report to local or Federal authorities on the number and cost of all prescriptions filled. These reports would be summarized and would ultimately reach Washington, where they would be analyzed statistically. The purpose of such reports would be to keep down the cost of prescriptions and to see that neither physicians nor druggists were breaking the rules and regulations set forth by the Government in regard to the kinds of drugs prescribed, the quantity, and the cost. And I might say that physicians would be held to strict account as to the exact number of pills, or capsules, or teaspoonfuls of medicine they prescribed.

I have mentioned one small part of the administrative machinery that would be set in motion were such a law as this enacted. Multiply all this tenfold, or worse still, a hundredfold, and you have part of the picture of the administration of national compulsory sickness insurance. Physicians would be called on the carpet for overprescribing, though they would not be punished for underprescribing. If a Government medical officer proved a case against a physician, the latter would be fined or might have the cost of the prescriptions in question deducted from his Government pay. Patients could be compelled to go to the hospital and to submit to courses of treatment if such procedures seemed necessary to protect the insurance funds. In communities having a panel system such as has been in operation in Great Britain for 35 years, insured persons who did not select a Government insurance practitioner would be arbitrarily assigned to a doctor. This is necessary because under a capitation system the people are regarded not so much as potential patients but merely as potential sources of income for doctors who would receive so much per head per year for the persons whose names appeared on their official lists.

Changes planned in medical practice.—It is not possible in a brief presentation such as this to go into the full implications of administration of national compulsory sickness insurance. But I wish to point out that such administration cannot avoid the methods of the police state. I wish further to point out that statements which have been issued by Federal officials and by other odvocates of so-called medical care insurance to the effect that there would be no appreciable change in the present form of medical practice have not told the truth. Some of the changes which are contemplated are: (1) A gradual change from the present fee-for-service basis of payment to a capitation or full-time salaried service; (2) the gradual abolition of the private practice of medicine and dentistry; (3) the gradual abolition of individual practice; (4) complete and absolute regimentation of patients and of health and medical personnel; and (5) control of all funds to be expended for health and medical services.

Both the public and the Congress are being led to suppose that there will be little if any change in the present methods of obtaining medical care and hospitalization. Thus, Dr. Joseph M. Mountin of the Public Health Service in testifying on S. 1606 stated: "There will be no need for an official 'authorization' for service of any kind; the patient will go directly to his doctor exactly as he does now. Only the problem of paying the bill out of his pocket at the time will be eliminated."

That statement is untrue. To begin with, insured persons will be compelled to select their doctors in advance of the time when they are ill if the capitation system is adopted as the proponents of this legislation claim will be the case. They will be compelled to go to doctors in their several health service areas if they wish to receive free services under the social-security system. If the doctor of a patient's choice lived in an adjoining service area, the insured person would be able to have that particular doctor only by paying privately for his services in addition to paying social-security taxes and increased income taxes. In time, insured persons would be compelled to go to doctors at public-health centers or clinics, for it is proposed to compel physicians to practice in groups at such public-health centers in order to save the insurance funds. Thus, such free choice as insured persons would have would exist at the moment of entry into the system. Thereafter they would be able to change doctors with difficulty and would probably be compelled to wait until the end of a quarter. By that time, of course, a patient might be dead.

Freedom of choice to be abolished.—That there is really no intention of letting people have free choice of a doctor is indicated by the attempt to decry freedom of choice as being a matter of no importance. The International Labor Organization, which has laid down the principles on which S. 1320 was drafted, states:

"The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem."

Carl Malmberg, of the Democratic National Committee, former ghost writer for Dr. Mountin of the Public Health Service and former clerk for one of the subcommittees of the Committee on Education and Labor, states in his book 140 Million Patients:

"Freedom of choice and personal relationship between physician and patient play not the slightest part in much of the very best medical care received in this country."

He then cites the case of persons going to the Mayo Clinic and to similar clinics. His statements are misleading in two respects: In the first place, a person goes to one of the great diagnostic or treatment clinics not for the day-by-day services of a family physician but for specialist diagnosis or treatment for cancer, diseases of the heart, or other serious conditions. Furthermore, even at these great central clinics it is possible to select a particular surgeon, internist, or other specialist if one so desires. The main point to bear in mind here, however, is that the general practitioners who are to be forced into the capitation system are not the physicians and surgeons found at the Mayo Clinic or at similar clinics; they are the family doctors who live down the street in your home town, the practitioners who handle 80 percent of the medical care of the country. And I might add that Malmberg is not stating the facts when he says that the health insurance bill "does nothing to abridge" free choice and personal relationships between physicians and patients (5).

That Federal officials have the fullest intention of changing completely the present form of medical practice is indicated in a report submitted to this committee in 1946 entitled "Medical Care Insurance a Social-Insurance Program for Personal-Health Services" prepared by Mr. I. S. Falk, who was largely responsible for S. 1606 of the Seventy-ninth Congress and S. 1320 which we are now considering (6). In regard to the methods of paying physicians he repeatedly indicates that the Government would use the capitation method or a full-time salaried service rather than the fee-for-service. In computing administrative costs and in giving illustrations of the ways things would work, he refers to the capitation method as though it were the desirable one and the one the medical profession would choose. Michael M. Davis, leading nongovernmental lobbyist for the nationalization of medicine, also decries the fee-for-service method of payment, stating that it "is most open to abuse by patients and physicians and is the most costly to administer. Adequate control of the services requires fiscal and professional supervision which is expensive and often vexatious. The promotion of quality and of prevention is difficult. The use of the fee-for-service method should therefore be discouraged, except for specialist services under certain conditions" (7).

Dr. Ernst P. Boas, another lobbyist for the nationalization of medicine, has stated: "Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained" (8).

It is perfectly apparent that the Federal Security officials who drafted S. 1320 have not the slightest intention of leaving the form of medical practice as it is now. Indeed, they insist that medical services must be organized and that such organization will be furthered if family doctors are paid on a capitation basis or on a salary basis. In the light of these statements, I submit that it is a gross misrepresentation of the methods of national compulsory medical care insurance to state or to imply that the only difference that this legislation would make is that patients would not pay for services at the time such services are rendered.

Is panel medicine America's choice?—I question whether the American people would look with favor on a capitation or panel system of medical practice. I question whether they would like to select their family physicians by going to the post office and picking a name from a list of doctors there posted. If their own doctor refused to sign up with the Government they would have to take someone else, or pay twice for their medical care, once to the physician of their choice, a second time to the Government. I think the only honest thing to do in presenting this legislation to the people is to tell them the truth about what it will mean. Explain to the mothers of this country that Congress thinks it is all foolishness for them to wish to have some particular obstetrician or pediatrician. Tell them that Congress would expect them to sign up with some general practitioner, and that they could not go to a baby specialist unless the Government insurance practitioner gave his permission. Indeed, it would be well to explain to the public at large that a patient would not ordinarily be able to have the services of a specialist unless an official O. K. were given by an insurance doctor.

I question, further, whether the American people, if consulted, would like the idea of being herded, willy-nilly, into public clinics as is planned. Ambulatory patients would be expected to go to such centers and to be cared for by salaried staff doctors who would work on 8-hour shifts. In New Zealand, which has a plan similar to the one proposed in S. 1320, people are not permitted to have their own doctors when they go to a hospital. Instead they are turned over to salaried staff doctors because that is administratively easy. These are a few of the contemplated changes. They are fully described in the reports of the International Labor Organization and in the reports emanating from the Social Security Administration. Thus we are to move step by step from the initial condition where many doctors would refuse to sign up with the Government to a stage 5 or 10 years hence, where more and more practitioners are expected to sign up until finally all of them would have come under Government control. The Social Security Administration plans are drawn for 5, 10, and 15 years hence. I refer here to the plans described in great detail in Senate Committee Print No. 5 of the Seventy-ninth Congress, second session, 1946, Medical Care Insurance by I. S. Falk.

Both Falk and Michael M. Davis advocate group practice which is to be carried on in Government health centers. The International Labor Organization advocates the same thing, stating, "In Russia the medical-care service is based on such centers." The draft schemes and plans of the ILO "almost unanimously advocate and encourage some form of group practice" at such Government centers. Thus it is evident that the Federal officials who advocate compulsory medical care insurance have not told the public the truth about what the law would do. Instead, they have smothered Congress and the public with voluminous documents that few persons can understand, full of contradictory statements. The patient is told, for instance, that when the law goes into effect he will receive a card entitling him to free medical care and hospitalization at any time from the doctor of his choice. He is told that perhaps he will not wish to choose a doctor until illness strikes. That is untrue. If the capitation system is in effect he will be compelled to select his doctor shortly after the system becomes operative, because the insurance doctors will have to have their lists of patients or they will not be paid by the Government. It is to be remembered that after the capitation system becomes operative, every insured person in a community must sign up with some doctor, for insured persons under such a system become simply "pathological entities" worth so much per head per year to the doctor on whose list they appear. If an insured person fails to sign up with a doctor he will be notified, say within 3 months, that he has been assigned to Dr. X or Dr. Y whose lists were not full. Is this regimentation?

Under the proposed capitation system the doctors would be paid their small annual fee whether they performed any services or not. In other words, each insurance doctor would be expected to assume the unlimited risk of the care of 1,000 to 1,250 patients, to give them all the services they might seek and that the Government demanded. This they would be expected to do for a limited, fixed fee of $5, or $6, or some other small amount per head per year. In New Zealand the capitation rate is $1.50 a year; in Great Britain it is $2.25.

I am quite certain that the members of this subcommittee will readily see that the capitation method of payment is wholly unfair. It is argued that medical services being too expensive to be paid for by the persons receiving the services, the burden is to be dumped on the doctors who are ordered to assume a major portion of the expense. They are told they must give all patients all the care they need for a flat sum of $5 or $6 a year. They would be put completely at the mercy of neurotics and of chronic patients whose large demands would not, however, entitle a doctor to receive any extra pay. I do not know of any other case in which services are performed either by trades or by professions in which there is no relation between the amount of pay received and the service performed. Organized labor would not agree to any such arrangement of payment for its own services. Yet this is what would be done to the medical, dental, and related professions under a capitation system. This is what is meant by regimentation of patients and practitioners.

ILO declares capitation system unfair.—That this capitation method of payment is unfair has been recognized even by the International Labor Organization itself, which points out that "the capitation fee system suffers from the fundamental defect that doctors receive an income inversely proportionate to the amount of work involved or given." To get around this inequity, the ILO proposes a basic salary augmented by capitation fees, or, alternatively, a full-time salary. In 1944 the ILO stated:

"A salary system is actually in force in Chile, Peru, Costa Rica, and Russia, and its introduction is proposed in the plans of the South African Medical Association, the Parliamentary Committee on Social Security and the National Health and Medical Research Council of Australia, and the Labour Party and the Socialist Medical Asociation of Great Britain" (9).

The Government planners have it clearly in mind to lead this country straight into the Russian form of medicine. Carl Malmberg states in his recent book, which is just off the press:

"Neither would compulsory health insurance necessarily be the final answer to our health problems. It is quite possible that the people of this country might some day decide to pay for all or most medical services out of general tax revenues, just as they pay for most educational services today. There would be many advantages in such a method. Great Britain has already taken a long step in that direction with enactment of its National Health Service Act. Sweden is moving in the same direction. In the next decade, several countries which now have compulsory health insurance will probably do likewise" (10).

What choices would remain to us, then, under a Government scheme of medical care, if the International Labor Organization condemns the capitation method of payment as unfair, and protagonists for compulsory sickness insurance insist that the fee-for-service method is administratively unworkable? Both of these statements are true. We are left, then, with a salaried Government service as the one preferred by the ILO, Russia, Carl Malmberg, and certain Federal officials. In fact, if the first two methods are unsatisfactory under a Government plan, one comes to the conclusion that a salaried service is inevitable for a comprehensive national system of Government medical care. But President Truman has stated, correctly, that "the American people want no such system."

In the light of these facts, it would appear that the Federal Security officials have brought the President face to face with an insoluble dilemma. For it is quite evident that they have led him to endorse a national health program which would lead to a system of state medicine with a salaried medical service, no freedom of choice, and the abolition of the private practice of medicine. Yet the President recognizes that the American people do not want such a system.

It is futile for the Federal Security officials to say: "This would not be socialized medicine." From the very beginning it would be at least partly socialized or state medicine under Federal control, and would constitute an immediate stepping stone to a salaried service. That is the plan; that is the experience elsewhere. The President was, therefore, in error when he stated in his message on a national health program, November 19, 1945:

"I repeat—what I am recommending is not socialized medicine.

"Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed" (11).

It is unfortunate that the officials who prepared that statement for the President sought to mislead him, the Congress, and the public by writing something they knew to be untrue.

It must be increasingly clear that the requests for these revolutionary changes are coming not from the people but from a small group of interested Federal officials. I cannot recall that any private citizens or the representatives of any considerable part of the population have appeared at these hearings urging the Congress to abandon the present form of medical practice in this country; nor have they urged that the panel system or a salaried Government service be adopted in lieu of the present system. I will return to this matter later, but at this point I wish simply to say that neither the Congress nor the public has yet had the facts about the form of medical practice that is contemplated under S. 1320 or about other matters of the greatest importance, namely, the costs, methods of administration, and the experience in other countries.

The establishment of a system of national compulsory medical-care insurance for the entire population would be an undertaking of colossal proportions. In no other country in the world has any similar scheme, of such proportions, been proposed save in Russia, which has a complete salaried service under a peculiar and meager form of national compulsory insurance operated by the Communist state without any direct payment of taxes by the people.

It is rather fortunate for us that there is available an illustration, on a small scale, of what might happen were we to try in this country such a scheme is as proposed in S. 1320. In 1938 New Zealand enacted a comprehensive social-security law similar to the one that has been proposed for the United States. I have described the experience in that country in detail in a brochure, New Zealand's Free Medical Benefits, which I submit for the record (exhibit D).

Costs.—Although this subcommittee is not directly responsible for passing on legislation dealing with taxation, I think you would not wish to approve a bill that would in all likelihood tend to bankrupt the country. Again it is necessary to view S. 1320 in its context in the total scheme of national social security. This particular bill would depend for financing on a charge of at least 3 percent on pay rolls—1½ percent on employers; 1½ percent on employees. The deficit would come out of general revenues. Most of the time the question of costs is dodged by Federal officials or not clearly presented, yet it is a matter of great importance, not only to Congress but to the people at large. Everyone is worried about rising taxes. I wonder how many people would be enthusiastic about social-security benefits and services if they were told in advance that after the omnibus social-security program was in full swing it would take some 20 to 25 percent of the national income. Employees would pay not less than 6 percent; employers 6 percent. The remaining 8, 10, or 12 percent would have to come from deficit financing or from general revenues (presumably from increased income taxes). At this point it is well to recall that, although it is only eight short years since a similar omnibus program was started in New Zealand, the system is in a state of financial collapse and is absorbing 40 percent of all revenues that can be collected. Deficit financing is already being resorted to before all the promised benefits can be put into motion. The New Zealand scheme might have been a blueprint for paradise, but now it looks more like a blueprint for chaos (exhibits D and E).

What would the free health and medical programs proposed in S. 1320 cost? I will not attempt to split hairs, but I believe an estimate of $50 per capita would be reasonable for medical care, hospitalization, dental care, and related services. That would be $7,000,000,000 a year, not counting initial administrative costs of possibly $700,000,000 a year and likewise not counting the cost of capital outlay for construction of hospitals, health centers, research centers, medical schools, and other educational facilities. Nor would those sums, huge as they are, allow anything for the expansion of public health services. Within 5 years, we might well be obliged to find some $10,000,000,000 a year for the national health program alone, not taking into account the cost of all the cash benefits promised under the remaining security legislation (14). If the program were sound and desirable, if similar proposals had proved effective elsewhere and had brought about great improvements in national health, then I think we should make every effort to see if such huge tax funds could be raised without placing an undue burden on the people.

Has any other country something better to offer than what the United States has?—What proof is there that if we destroy the present system of American medicine, if we thus burden ourselves to the breaking point with far heavier taxes than we now bear, and if we bow to the heavy hand of bureaucratic control—what proof, I ask, do we have that the rewards we might receive would be worth the price we would have paid? Repeatedly this subcommittee has been told that a system of national compulsory medical care insurance will go a long way toward solving the problems of the distribution of medical care. Repeatedly you have been told that physicians will be distributed more equitably, that rural areas will be better served, and that economically depressed areas will attract more doctors. Repeatedly you have been told that the shocking health conditions in the United States will be ameliorated if you will but enact S. 1320 or some similar piece of compulsory legislation.

But has any witness come forward to give you an illustration of a country which has tried compulsory sickness insurance on such a vast scale with success? Do we wish to follow in the footsteps of Germany or Great Britain, which tried the scheme on a modest scale, or of Russia, which went all the way to communism? Have we any reason to envy the health conditions of the people in those countries? Had we any reason to envy those conditions before the war? Statistics have been presented to you and have been widely circulated that make it appear the United States makes a poor showing in regard to health indices.

Without going into details, I may say that much of the material presented to you by Government officials has been purposely misleading and has been given to you for the purpose of selling legislation that would confer vast powers on the persons who drafted the bills. For instance, there have been given to you and to the public tables of comparative mortality rates, so presented as to make the United States appear at a disadvantage. In general, I may say that international vital statistics are not recorded or compiled on comparable bases from country to country. Whenever statistics are used they should be presented with entire candor and with explanations as to their shortcomings. Unfortunately such candor has been lacking in much of the material presented to this subcommittee by Government witnesses. You have heard the testimony of Dr. Maurice H. Friedman in which the reliability of reports emanating from the Bureau of Research and Statistics, Social Security Administration, has been successfully challenged. These reports have also been challenged by Dr. Elizabeth W. Wilson in her recent volume on Compulsory Health Insurance. The credibility of the top Federal officials in that Bureau has been questioned justifiably. We must therefore proceed with caution in coming to any conclusions on national health if they are based on reports from the Social Security Administration.

European experience summarized.—Insofar as European and other foreign experience with compulsory sickness insurance is concerned, we may conclude at least this much:

1. *The coverage has generally been for a small part of the population in the beginning and has gradually increased over several decades until complete or nearly complete coverage has been attained.*—Thus in Germany Bismarck's sickness-insurance scheme was limited to 10 percent of the population—the very poorest people who were in danger of becoming public charges. After 50 years about two-thirds of the population was receiving Government insurance medical care. Great Britain started with limited coverage and gradually worked up to 40 percent of the population during a period of about 35 years. This year it is planned to nationalize medicine in Great Britain, to compel everyone to accept public medicine, to compel all physicians to become servants of the state. Russia started a national health-insurance scheme under the Czars in 1911. The Soviet Government accepted the czarist scheme and today the entire population is subject to a system of state medicine. All doctors are servants of the state; there is virtually no private practice. In New Zealand the attempt was made to socialize medicine overnight and to bring in the whole population at one time. It is 8 years since the law was passed and the system is still in a chaotic condition. The point is that the trend is from a little compulsion to total compulsion, from health insurance with some state medicine to a condition of complete state medicine.

2. *The number of days of illness has increased and the costs of the system have risen in countries which have inaugurated complsory Government plans for distribution of medical care.*—The reasons for this rise are largely psychological and economic (exhibit E).

3. *Taxes have been put at a low figure at the start in order to sell the idea to labor, to the public at large, and to legislators.*—As the costs rise one of several things happens: (1) Taxes are increased to meet the deficit, (2) benefits are limited, and (3) rates of payment to professional personnel are cut. The limiting of benefits tends to a downward leveling of health and medical services. As rates of pay are cut there is the downward leveling of professional incomes and resultant discouragement among practitioners who are inadequately rewarded for professional services.

4. *Medical-care insurance—i. e., compulsory sickness insurance—has been costly to the insured population.*—The savings spoken of in advance do not materialize (13).

5. *Doctors are not more equitably distributed.*—If doctors are ever to be induced to go to rural areas the inducements that might be offered, such as better hospital facilities and more adequate incomes, can probably better be provided outside of a compulsory insurance system than within it. But rural practice will not neces-

sarily be made attractive merely by providing hospitals and better incomes. Many communities have little to offer to professional men and their families. Proposals for the solution of this problem have been made, but they do not require national compulsion.

6. *Methods of payment have profoundly affected the quality of medical services.*—New Zealand is a recent example of the effect of methods of payment on the quality of health and medical services. (See exhibit D.) For further discussion see Sulzbach (15).

7. *Medical services have not improved under compulsory sickness insurance* (*exhibit G*).—There is a voluminous literature on the subject.

8. Mortality rates have declined in all countries in considerable measure as a result of preventive health services, but sickness rates have increased greatly in countries having compulsory sickness insurance. The duration of illness among members of German sickness funds increased from 14.1 days in 1885 to 29.3 days in 1932 (16).

9. *Malingering is the universal and inescapable curse of the cash sickness-benefits program of compulsory sickness and invalidity insurance.*—"The phenomenon transcends nations and classes" (17).

10. *There is great danger in developing huge Federal trust funds.*—Such funds would be a constant temptation. There would be pressure for more and larger benefits. Governments are tempted to spend the funds for purposes other than those originally intended. In Germany the reserves "were either lent to the Government or used for purposes for which the Government would otherwise have had to use its own resources" (18).

11. *Patients and practitioners alike have been deprived of freedom of choice when compulsory insurance has been made universal.*—Ultimately no one can remain out of the system when the entire population is taxed to support the system and everyone is promised free benefits.

"It is not compulsory health insurance as such that affects the medical profession in the first place, but the percentage of the population which it covers. * * * In Germany, the doctors kept a substantial independence since they earned a generous 40 percent of their incomes through private practice" (19). In New Zealand a modicum of freedom was retained by physicians and patients after the original social security act was amended for that purpose. But there is the constant threat that the New Zealand Government will outlaw the private practice of medicine. The ILO admits that private practice will disappear under a universal system of sickness insurance for the entire population (20).

12. "*Social insurance has the tendency to expand beyond the scope originally envisaged.*—Driving forces behind its expansion are the vested interests of the bureaucracy and the general lack of comprehension of the consequences involved" (21).

RECOMMENDATIONS

I shall make two sets of recommendations, one professional, the other professional-political (admitting that they mix but poorly).

Recommendation I.—A. In the light of the volue of conflicting testimony which has been offered and the well-substantiated attacks by competent authorities on the credibility of some Government witnesses and reports, I think this subcommittee would be acting in the best interests of the public if it withdrew health legislation of the type embodied in S. 545 and S. 1320 entirely from the political arena pending further investigation of certain officials in the Federal Security Agency.

Much of the thinking of the Congress and of the public regarding so-called "unmet health needs" and the urgent necessity for Federal intervention with respect to the distribution of medical care and related services has been shaped by reports which have been put out by the Social Security Board (now Administration). Certain of these reports have been purposely biased and intertionally misleading. Although the FSA has access to health and medical reports from all parts of the world and although its top officials at the bureau level are fully cognizant of the importance of honest interpretations of factual material, the Congress for nearly a decade has been misled by those officials deliberately for selfish purposes not in the public interest. The officials in question cannot plead to be ignorant of the significance of their actions. Being highly trained, they know what they are doing. But because of their high training they are doubly responsible to the Congress and to the public. Noblesse oblige! Some of those officials have failed to regard a public office as a public trust. They have issued, or connived at the issuance of, inaccurate reports published at public expense and mailed in large quantities under the Government frank. The reports have been initiated by these officials for the purpose of influencing the Congress and of creating a climate of opinion favorable to the type of legislation which they themselves have written. Were the legislation enacted the officials in question would be likely to profit greatly in increased salaries, power, and prestige (exhibits H and I).

Since the reliability and trustworthiness of some statistics, reports, interpretations emanating from the Bureau of Research and Statistics and from other bureaus in the Federal Security Agency are in question and since the officials responsible for such statistics, reports, and interpretations are, or have recently been, under investigation by the Harness Subcommittee on Publicity and Propaganda of the House Committee on Expenditures, and by the Department of Justice and the Federal Bureau of Investigation, I believe this subcommittee would be justified in questioning the basic need for any legislation in the field of personal health services, at least until these several investigations have been completed and Congress has had full reports.

B. Since the broad field of social-security legislation is extremely complex and since legislation therein may be referred either to the Finance Committee or to the Committee on Labor and Public Welfare, depending on whether or not taxing provisions are included in the bills being referred, it is obvious that the members of the two committees have little or no opportunity to know about what occurs at hearings or at meetings of advisory councils of the respective committees. Thus, I doubt if this committee is aware of the startling proposals which Commissioner Altmeyer made before the advisory council of the Finance Committee on December 4, 1947, and on December 16 and 17, 1947. I doubt if this committee has followed the activities of Federal Security officials in engineering legislation through the Senate Committee on Expenditures in the Executive Departments.

Since Federal officials are working on many fronts in Congress to insure enactment of bills which they have written and promoted, I recommend that a Joint Congressional Committee on Social Security be set up and that any new proposals be referred ultimately to that committee before action is taken. If such a plan is not feasible I recommend that some other arrangement directed to the same end be considered so that piecemeal social-security legislation may not be approved without the fullest understanding of the position and significance of such legislation in the whole social-security scheme.

C. If a Joint Congressional Committee on Social Security or some similar body be created, I suggest that its first duty be to study the desirability of repealing the Social Security Act before the Nation is entirely engulfed by the legislative program which is being promoted. If we do not save ourselves now, I believe we are headed straight for state socialism and dictatorship via a comprehensive scheme of national compulsory social security for the entire population. If the Congress fails to see the whole picture and fails to act, the Nation is in grave danger of succumbing to a dual-purpose social-security program designed to tax, and tax, and tax—rule, regulate, and regiment.

Recommendation II.—If the subcommittee for political or other reasons should decide that it wished to report some bill out during this session of Congress, then I suggest consideration of the following provisions:

A. Creation of a Nationaly Health Agency for the purpose of bringing together the health and medical functions of the Federal Government in a single independent agency entirely free of domination by the Federal Security Agency. Such a health agency would be autonomous, deriving its powers, authority, and funds directly from the Congress. Title I of S. 545 calls for creation of such an independent agency. I believe this title should supersede S. 140 which would create a tripartite Department of Health, Education, and Security by elevating the present Federal Security Agency to departmental level. The most controversial issues in this title are found in sections 101 and 104 and relate to: (1) The qualifications of the National Health Administrator, (2) the qualifications of the Director of the Office of Medical and Hospital Care Services, and (3) the constituent units in the Agency. (I can furnish detailed views on these issues when and if the subcommittee decides to act on title I.)

B. *Authorization of $4,000,000 for surveys of health needs.*—$3,000,000 for medical-care survey and $1,000,000 for dental survey. The Congress clearly should know why it is going anywhere in the field of personal health services and if it decides to enter the field, it should know where it is going. A simple questionnaire has already been sent to the governors of the States asking for their preference between S. 545 and S. 1320. They have not shown enthusiasm for S. 1320, but perhaps if you had given them a third choice of no bill at all, they might all have voted unanimously to be let alone.

However, I think it should be generally agreed that there is real need for a bona fide, unbiased survey of the country's health needs. The national health survey of 1935, a WPA project, has always been suspect. The original questionnaires have been bled white during the years. We need an objective, fact-finding survey not designed to prove anything but to get at the truth about the condition of the Nation's health. Many States have completed hospital surveys and would now be ready to round out the picture by surveying medical and dental needs. The reports from the States should not go to the Federal Security Agency as now constituted. Indeed, they might be forwarded directly to this subcommittee for study and analysis, although that would involve utilization of a larger staff than is now available.

C. *Action on titles VII and VIII of S. 545 to be deferred until completion of surveys.*—If the subcommittee should decide not to defer action on these titles then I would urge sharpening of the language of section 712 (4) which deals with the use of Federal funds for payment of premiums to voluntary, nonprofit medical, hospital, or other insurance funds. The purpose of this section was to stimulate the voluntary insurance movement. The section would, however, create friction between nonprofit and profit insurance funds and might lead, through subsidy, to an unfair interference with the private insurante industry. I think, too, it is well to realize that voluntary insurance if it becomes too large will not only tend to take on the characteristics of governmental insurance but may open up the way to capture by the Federal Government. Voluntary sickness insurance has ever been the precursor to compulsory sickness insurance.

There is another danger to be guarded against in title VII. If the program for medical care for the low-income groups were to be administered by State health departments there would be considerable likelihood that the influx of large sums of Federal money would so increase the power of those departments, especially in the larger States, that they might set up State funds and develop compulsory insurance programs. Such a development would not necessarily mean that the States desired compulsory insurance but that active, powerful minorities in official State agencies were proceeding at the State level just as such minorities have proceeded at the Federal level.

D. *Authorization of funds for expansion of public health services as proposed in title III of S. 1320.*—I believe that if Congress wishes to spend money for improvement of national health it could do no better than increase the appropriations of the Public Health Service for work in the field of preventive medicine. You are likely to get a better return on your money if you spend it on stamping out disease than if you pour it out on an enormous, complex, and uncertain system of social insurance.

E. *Limitation of grants-in-aid, except for surveys and public health services, to States which are definitely in need and which seek Federal funds.*—Most of the clamor about the needs of the poor States seems to come from Washington rather than from the States themselves.

F. *Deferral of action on bills for school-health services until States have reported on their needs and wishes.*

BIBLIOGRAPHY

1. Sulzbach, Walter, German Experience With Social Insurance, Studies in Individual and Collective Security No. 2, National Industrial Conference Board, page 2.
2. Ibid., page 2.
3. Social Security: Principles and Problems Arising Out of the War, International Labor Organization, Geneva, 1944, Report IV (1), page 59.
4. Malmberg, Carl, 140 Million Patients, 1947, page 185.
5. Ibid., page 186.
6. Falk, Isidore Sidney, Medical Care Insurance a Social Insurance Program for Personal Health Services, Senate Committee Print No. 5, Seventy-ninth Congress, second session. Report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate, July 8, 1946.
7. Principles of a Nation-wide Health Program, Report of the Health Program Conference, 1944, published with the cooperation of the Committee on Research in Medical Economics, of which Michael M. Davis is chairman and Ernst P. Boas, M. D., is a member. Both of these men are lobbyists for national compulsory sickness-insurance legislation.

8. Boas, Ernst P., M. D., Why Do We Need Health Insurance? No date, page 13.
9. Social Security: Principles and Problems Arising Out of the War, op. cit., pages 89, 90.
10. Malmberg, Carl, op. cit., page 230.
11. Message of President Truman on a National Health Program, November 19, 1945.
12. Wilson, Elizabeth W., Compulsory Health Insurance, Studies in Individual and Collective Security No. 3, National Industrial Conference Board, 1947, pages 77–91.
13. Ibid., pages 73, 89, and 90.
14. Dr. Wilson, op. cit., estimating costs on a different basis has also arrived at a possible total of $10,000,000,000 a year.
15. Sulzbach, Walter, op. cit., pages 33–37.
16. Ibid., page 24.
17. Ibid., pages 22–32.
18. Ibid., page 92.
19. Ibid., pages 114–115.
20. Approaches to Social Security, International Labor Organization, Montreal, 1942, pages 50–51.
21. Sulzbach, op., cit., page 132.

EXHIBITS

A. Digest of S. 1050; digest of S. 1606.
B. Statement by Commissioner Arthur J. Altmeyer on December 4, 1947, before the advisory council of the Senate Finance Committee.
C. Regulative Interference Under the W-M-D Bills, by Marjorie Shearon, Socialized Medicine, volume I, No. 4, 1948.
D. New Zealand's Free Medical Benefits, by Marjorie Shearon, Socialized Medicine, Volume I, No. 5, 1948.
E. Paradise Unlimited! The Menace of the Police State, by Marjorie Shearon, Socialized Medicine, volume I, No. 2, 1948.
F. Hiatus in Sickness Insurance, reprint of article by A. M. Simons from the Christian Science Monitor, January 4, 1947.
G. Bureaucratic Control of Medicine, by Marjorie Shearon, Socialized Medicine, volume I, No. 3, 1948.
H. Federal Propaganda for the Welfare State, by Marjorie Shearon, Socialized Medicine, volume I, No. 1, second printing, 1948.
I. Blueprint for the Nationalization of Medicine—Plans to Enchain Medicine by Unwarranted Regulative Interference, by Marjorie Shearon, third printing, 1947.

Senator **Donnell**. Miss Stein requested permission a few days ago to insert into the record a statement which she or her organization desired to make. May I inquire, Miss Stein, how soon that will be available for insertion?

Miss **Margaret Stein**. Senator, I believe my request to Senator Smith was, Could the record be kept open in the event our office would want to answer some of the remarks Dr. Shearon made. I did not say I would want to. I hope to know within 2 or 3 days.

Senator **Donnell**. You would like, say, 5 days from now, is that right, for your organization, if it desires, to make an insertion? Very well. I have no doubt, Miss Stein, that you will observe the same admonition to keep it within reasonable bounds. That is not meant to be unduly restrictive, but I hope you will use the best judgment in the quantity that is inserted.

The record of the hearings on these two bills, S. 545 and S. 1320, will be held open until the committee or its chairman shall have formally closed the record.

Unless there is something further this afternoon, the subcommittee stands in recess, subject to the call of the chairman.

(Whereupon, at 2:45 o'clock p. m., the subcommittee adjourned, subject to the call of the chairman.)

(Subsequently Senator Murray addressed the chairman as follows:)

UNITED STATES SENATE,
COMMITTEE ON PUBLIC LANDS,
June 9, 1948.

HON. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Senate Committee on Labor and Public Welfare,
Washington 25, D. C.

DEAR SENATOR SMITH: I have submitted to Mr. Rodgers, for inclusion in the record of our hearings on S. 545 and S. 1320, certain comments and materials bearing on the activities of the National Physicians Committee.

The NPC has spent over $100,000 during the first 3 months of 1948 alone. It has spent it to bring constantly increasing pressure of the most pernicious sort to bear on members of the Congress—particularly through the distribution of vast quantities of false, misleading, and vicious propaganda obviously designed to influence the forthcoming election.

Because these activities appear to me to unquestionably involve violations of the law on the part of the NPC and of its contributors, I am requesting the Department of Justice to investigate its operations so that the nature of its activities may be exposed to the many doctors it has misled and its illegal activities brought to a halt.

Since I believe that you, our colleagues on the committee, and everyone interested in the legislation before us will want to be apprised of this situation, I am asking Mr. Rodgers to insert a copy of this communication in the record as an introduction to my comments on this organization. I know that you yourself have a most sincere interest in establishing the motivation and character of all organizations attempting to influence us on matters so profoundly important to the health of the nation.

Respectfully,

JAMES E. MURRAY.

THE NATIONAL PHYSICIANS COMMITTEE

This organization calls itself the National *Physicians* Committee for the *Extension of Medical Service*—A *nonpolitical, nonprofit* organization for maintaining *ethical* and scientific standards and extending medical service to all the people. [Italics mine.] As regards those italicized words I believe the following comments should be brought to the attention of the Congress and of the thousands of decent, honorable doctors in this country in whose name this committee claims to act.

It calls itself a "Physicians Committee." Yet, required by law to list all contributions of $500 or more, its 1947 registration does not list a single physician. It does show $72,000 in contributions from drug manufacturers. And again, in reporting contributors during the first 3 months of 1948, not a single physician is listed whereas "patent medicine" men are shown to have contributed $53 500. Some of the implications of this situation to physicians and to the public are stated in atttachment No. 1 below. Others are to be found in investigating the applicability of those provisions of the Corrupt Practices Act and of the Taft-Hartley law relative to contributions by corporations being used to influence elections. Still others are to be found in the strange jugglery of funds involved in (1) NPC's deciding not to accept contributions from drug houses after the passage of the lobbying act (2) the hurried creation of a so-called Medical Services Foundation which exchanged some $40,000 with the NPC during 1947 (3) the dissolution of the Medical Services Foundation in December 1947 with all contributions made to it being returned to their donors, evidently without the foundation's having done the work it was created for, and, apparently by prior arrangement (4) the recontribution of those funds to the National Physicians Committee (see attachment No. 5 below).

The committee is supposedly created for extending medical service to all the people but, although it has spent hundreds of thousands of dollars in propaganda against measures aimed at such extension, there is no record of its having spent a nickel in such a way as to extend medical care to anyone.

It calls itself nonpolitical. Yet it is registered as a lobbying organization and its representatives infest the Halls of the Congress.

It calls itself nonprofit but the three laymen who seem to run it profit directly to the tune of ten to twenty-thousand dollar salaries plus apparently unlimited expense accounts. And the implications in attachments 1 and 2 that certain individuals may be profiting indirectly as well certainly warrants specific investigation.

It calls itself ethical and claims to speak in the names of great numbers of doctors who unquestionably are. In fact, its operations have always been characterized by a complete absence of ethics. Its utterances are slanderous and it engages in character assassination. As was brought out in earlier hearings, it has consciously misled contributors into violations of our tax laws. Attachment No. 1 indicates one attempt at bribery and attachment No. 6 refers to its having stooped so low as to attempt to bribe the press.

Just as its letterhead is a bundle of lies, so too is its continued existence a libel on the medical profession of this country and a threat to the democratic processes of our Government. Its continued endorsement by the American Medical Association reflects one phase of the leadership of that organization which is altogether inexplicable. Equally inexplicable is the fact that when the firm of Raymond Rich Associates was employed as public relations counsel to the AMA (at the order of its house of delegates) and offered to investigate and give a complete report on the National Physicians Committee for the nominal fee of $5, the offer was refused by the officers of the AMA. One cannot but wonder why those officers urged doctors to contribute to the NPC against the advice of a highly reputable firm employed by those same doctors and at the same time refused to permit the firm to tell the doctors just how the NPC was operating.

Mention should also be made of the fact that Miss Elizabeth Wilson, whose articles on health insurance have been referred to at the hearings as "impartial" is also in receipt of funds from the National Physicians Commttee. I mention this not as an inference that Miss Wilson has been guilty of any improper conduct. I do not know of any such. I believe, however, that we should keep the fact in mind in evaluating any materials which may have appeared under her name or any speeches which she may have made since she began to accept moneys from this organization.

Finally, I should like to say that I am considerably perturbed to find pharmaceutical manufacturers contributing to this so-called Physicians Committee. A list of those contributors is attached. Several of them have heretofore enjoyed excellent reputations. Inasmuch as they would have no apparent self-interest in opposing legislation which, by making medical care more accessible to our people, would also create a more effective demand for necessary drugs, I have cast about for an explanation of their contributions to the NPC. It is possible that they did not investigate the NPC themselves but merely accepted the AMA's endorsement of it as sufficient guaranty of an integrity which does not exist. It may be that the AMA's grant of "approval" to certain drug products has a bearing on the matter. Or it may be that a third explanation which has been suggested to me is the true one. However, this latter suggestion would be so damaging to the reputations of these establishments and perhaps to the sale of their products that its disclosure would be most unfair unless its truth was established. I am having the matter investigated and, as soon as those investigations are completed, will report my findings to the members of the committee, to the Congress, and to the people.

The following attachments all shed some further light on this so-called Physicians Committee. I commend them to your attention.

NPC attachment No. 1

(Prepared by an employee of the Republican National Committee then acting as adviser to Republican Senator Robert A. Taft)

AUGUST 14, 1946.

MEMORANDUM TO MEMBERS OF THE BOARD OF DIRECTORS OF THE NATIONAL PHYSICIANS COMMITTEE

Herewith is a statement which I am mailing to a number of physicians and surgeons who have been receiving news releases and research material from me during the Seventy-ninth session of Congress.

I wish to make myself entirely clear and to state that I am not casting any reflection on members of the board of directors of the NPC in what I say about the activities of their paid staff. I believe the board was actuated by the highest motives when it undertook to inform the public and the medical profession about the contributions of American medicine and about current Federal legislation in the health field. But I think there is no doubt the paid staff of promoters has done many things that would horrify the board of directors if they knew about what has been going on.

American medicine will face a great threat during this next session of Congress, if not before. It will need to be strong. It will need sound professional leadership. It will need to stand forth in the public eye without the dark mantle which has been draped on its shoulders by those who regard the medical profession as a "good thing" financially. Physicians and surgeons are unusually guileless, and I think it is highly probable that in this instance the Pratt organization of the NPC has imposed upon a board of directors which is, in the main, preoccupied with professional duties and wholly unaware of the unprofessional conduct of its paid representatives in Washington and elsewhere. Has the prior history of Pratt been such as to justify the confidence which you have had in him? Has he in earlier activities used large sums of money wisely?

Because I believe that the best way to correct any evil is to throw the bright light of publicity on it, I am mailing the enclosed statement, at my own expense, to you who are the responsible heads of the NPC and to a small number of other doctors of medicine who have the interests of their profession at heart.

MARJORIE SHEARON, Ph. D.

AUGUST 12, 1946.

THE NATIONAL PHYSICIANS' COMMITTEE

I have refused to cooperate with the NPC because:

1. NPC publications have been misleading and have failed to give to the medical profession the carefully prepared, scientifically accurate, and objectively informative material which the profession should have. Social insurance, especially sickness insurance, legislation is highly technical. Analyses and interpretations thereof should be made by professionally qualified persons. Judging from the NPC releases, it would seem such professional assistance has not been obtained.

2. The facts about nationalization of medicine speak for themselves and, unembellished, are sufficiently alarming. They do not require yellow journalism distortion. The NPC supplied the medical profession and the public with sheer buncombe. The booklet on the 1943 W-M-D bill was particularly reprehensible. One may hardly expect that the forthcoming NPC brochure, which will be sent to every doctor of medicine, will be calmly analytical or factually accurate. I believe the profession is entitled to informative material of great scientific accuracy in order that it may form sound judgments on matters of high policy. It seems to me action should be based on knowledge and reason not on half-truths and emotions arising from artifically induced fears.

3. Evidence given at the hearings on S. 1606 indicates the NPC receives a considerable proportion of its backing from the drug industry. Why should the medical profession, which is a reputable and honorable one, altruistically devoted to the service of humanity, have its "educational" campaign, or, more correctly speaking, its legislative lobbying activities financed in considerable measure by a purely commercial group such as the drug industry? Why should a group which is seeking to preserve the lucrative but scientifically indefensible and socially wasteful patent medicine business dictate high policy for the medical profession whose objectives are so totally different?

4. The NPC from its own testimony appears to be vulnerable in regard to its dealings with the Bureau of Internal Revenue. Enemies of medicine have not failed to capitalize on the NPC admissions.

5. Edw. F. Stegen, Associate Administrator of the NPC, has not, in my opinion, conducted himself in accordance with accepted professional standards of conduct. Stegen came to me in April of this year and offered to furnish clerical workers and research assistants gratis to help me in preparing research material for the Senators in connection with my work on the hearings on S. 1606. I explained it would be improper for me to accept financial aid from any lobbying group, because there would be implicit in such an arrangement the thought or expectation that I would use my real or fancied influence with the Senators to favor the NPC at hearings and that I would color my research findings in a way

agreeable to that particular lobbying group. Implicit also would be the idea that the NPC had bought an inside track to those minority Senators most active in shaping party policy regarding compulsory sickness insurance and related legislation.

Stegen countered by proposing that the NPC would make a substantial contribution to the Republican National Committee to be earmarked for my use. He assured me it could all be quietly arranged—or words to that effect—so that no one, not even the donor of the gift, would be the wiser. I turned the proposition down cold. To clinch the matter, I called the Republican National Committee while Stegen was in my office and inquired if headquarters desired political contributions on such terms. They did not.

I felt considerable indignation that Stegen had dared to make such a suggestion to me. I believe there is not a single reputable physician who would thus have proposed, none too subtly, to purchase a lien on my professional services to Republican Senators. I could not but wonder first, whether Stegen thought I was naive, or devious, or downright crooked, and second, whether he was expanding the influence of the NPC by making similar propositions to other persons who, in his estimation, might prove useful. Surely he knew exactly what he was doing and what was implicit in his offer. By the same token, he must have known that a person serving as I was as consultant to members of various Senate committees could not be in the pay of, or could not be financially indebted to, any lobbying group. Can one believe that Stegen was unaware such a secret arrangement of the type he proposed—assuring it could be made—would be highly improper and wholly incompatible with professional ethics? The promotional activities of Stegen indicate he lacks the perspicacity to see that the Senate consultant who could be bought for one side would be equally susceptible of purchase by the opposing side and would be likely to be available to the highest bidder.

6. The Washington representative of the NPC, Arthur L. Conrad, Associate Administrator of the NPC, in my opinion, is exceptionally unqualified to represent the physicians and surgeons of the United States. Lacking background and professional experience, he has yet taken it upon himself to speak for American medicine. With the irresponsible heedlessness of a child placing sticks of dynamite in the path of an express train, he threw a monkey wrench into the legislative works when he endeavored to block support of the Taft-Ball-Smith bill (S. 2143) by (1) representing himself as the spokesman on high policy for American medicine, and (2) attempting to discredit me professionally. At the very time I was devoting my entire energies and much of my own time to developing a plan of effective, penetrating examination of witnesses appearing at hearings on S. 1606, Conrad put on a little private smear campaign of his own for the purpose of discrediting me with one of the Republican Senators who was prominent in defending the medical profession and with whom I was working daily.

What was Conrad's purpose? Did he speak for American medicine? If he did not, for whom did he speak and on what authority? Would it have aided the cause of the medical profession if Conrad had been successful in discrediting me? In this connection, it should be remembered that I am the only Government expert in the field of health insurance who is opposing the nationalization of medicine. My opposition is a matter of deep conviction that the whole plan is scientifically unwise, politically inexpedient, administratively unsound, and socially undesirable. I have offered consistent opposition to the Falk machine, repeatedly jeopardizing my own economic security to do so, over a period of nearly a decade.

However, Conrad's attack on me was a matter of small moment compared to his stupid and ill-advised efforts to block support for S. 2143. Conrad himself told me he had merely glanced over the bill. Yet he did not hesitate to condemn it, to call it a hodge-podge, and to say he thought the Republicans were introducing it simply to be able to say they had introduced something. (These were not his exact words, but the gist.) When he was asked by one of the Senators who intended to sponsor the bill to put his objections in writing, he excused himself on the grounds he was flying to Chicago. If he chose to blast the Taft bill during the week before it was introduced, he should have given his reasons for disapproval, especially when asked to do so by the Senator whom he sought to influence.

As a matter of fact, there were excellent political and professional reasons for introducing S. 2143 early in May and for not seeking bipartisan support at that time. Conrad, who is not yet dry behind the ears and who is too inexperienced to be in the key position he occupies, failed to grasp the situation. He created considerable disturbance behind the scenes, and, whether by design or ineptness, damaged the cause he was paid to serve.

7. I am not convinced the NPC discussion group, which early in May delivered a statement on high policy regarding national health legislation, really represented the medical profession or was working in the best interests of the profession. Over the week end before S. 2143 was introduced, an NPC discussion group met and formulated a policy statement regarding the national health legislative program desired by American medicine. Was that group authorized to represent American medicine? I think it was not. I checked with responsible physicians and found that such authorization had not been given. What, then, is the meaning of such activities? Who really is dictating the policies of the medical profession? Is a group of newspapermen, promotion wizards, and public relations experts competent to speak for American medicine? Can the medical profession, which is being attacked by labor, Government officials, the radical press, and private lobbying groups, afford to jeopardize its position still further by entrusting its public relations to the NPC?

8. I doubt if the members of the board of trustees of the NPC, who are, I take it, physicians of high standing and unquestioned probity, have any clear picture of what goes on in Washington in their name. I strongly suspect that some very good men have been taken in by a group that is not serving the best interests of medicine.

For all these reasons and others, too, I do not cooperate with the National Physicians Committee.

* * * * * * *

Because of the personal character of this statement, I am mailing it at my own expense, not using the Government frank. I speak for myself alone: There is nothing official in my remarks. I seek to clarify my own position and also to give members of the medical profession a picture of what goes on in Washington.

MARJORIE SHEARON, Ph. D.

My insertion of the above documents does not necessarily mean that I agree with their author's implication that Senator Taft's health bill, S. 2143, was drafted and introduced at a particular time for "political" reasons rather than because of a sincere interest in the Nation's health.

NPC attachment No. 2

[Excerpts from report on public relations to the trustees of the American Medical Association June 15, 1946]

RELATIONS WITH THE NATIONAL PHYSICIANS COMMITTEE

With the exception of a few individuals, most of whom were interested parties, no one whom we have consulted has had anything favorable to say about the National Physicians Committee. The charges regarding gross inaccuracies and other inappropriate contents in the committee's publications are too widespread to be ignored; likewise, a widespread rumor of unsavory character regarding certain channels through which some of the funds are alleged to flow. Furthermore, the recent appearance of a committee spokesman before the Senate hearings made, we would say, a highly unfavorable impression, although this has been obscured from the readers of the American Medical Association Journal. (The journal's condensed report omitted, by actual count of paragraphs and pages, over 78 percent of the testimony.)

We recognize that there is no organic connection between this committee and the American Medical Association. But it cannot be denied that the committee has worked in relatively close, though for the most part invisible, contact with the American Medical Association. Hence there appears to the public to be a dubious relationship which we are certain has injured the American Medical Association's public relations.

An additional injury comes from a further consideration. By letting another organization be the chief opponent to measures which the American Medical Association does not like, the association not only loses control of the methods used but also lays itself open to the suspicion that perhaps its case is not too well founded; otherwise it would conduct its own propaganda on its own responsibility.

We are, of course, acquainted with the arguments regarding the danger of becoming liable for heavy taxes. Now, however, that the association has been reclassified by the Bureau of Internal Revenue this possibility has ended—the association can now engage in any amount of legislative activity without becoming liable to additional taxes beyond those for social security which it is already paying.

We recommend, therefore, that no further encouragement or participation in its activities be given to the National Physicians Committee, and that there be under no circumstances any interlocking trusteeships.

RAYMOND RICH ASSOCIATES,
New York.

NOTE.—Raymond Rich Associates has an outstanding reputation for integrity and honesty in the field of public relations. When this report was written the firm was serving as public relations adviser to the American Medical Association, having been retained by the officers of that association by instruction of its house of delegates. Subsequently it resigned from the employ of the AMA after it had become convinced that it could not work for the AMA and retain its professional integrity. The letter of resignation sent by Raymond Rich Associates to the AMA and setting forth in detail the reasons for that resignation has been introduced into the record of these hearings by Senator McGrath. (See vol. 3. pp. 1516–1535.)

NPC attachment No. 3

[From the New York Post, December 31, 1947]

PHYSICIAN LOBBY USES RED HERRING LIES IN BATTLE ON NATIONAL HEALTH INSURANCE

WASHINGTON, December 31.—Most formidable of the 1948 lobbying campaigns will be undertaken by the misnamed National Physicians Committee for the extension of medical services.

The NPC acts as legislative strongarm for American Medical Association—reactionaries who are determined to block the extension of medical services under a system of national health insurance. It is strictly negative in character.

Not content with pouring out $1,000,000 on propaganda during the past 6 years, the NPC has decided to double next year its 1947 lobbying fund of $300,000. Literature almost unbelievably salted with distortion is already being issued to promote the drive for contributions.

The Nation's doctors are asked to sign "year of decision certificates." These include the statement: "I want to do my share to preserve for the citizens of the United States our system of private medical practice." The medicos also are being asked to enclose checks for any amount from $10 to $499.

The $499 top is designed to avoid provision in the lobby law requiring a report on all individual contributions of $500 or more.

Accompanying literature includes a pointed recommendation from the AMA, plus an article by President Louis A. Buie, of the Minnesota State Medical Association, making such assertions as these:

1. Government employees are "trying to create the impression that there is a great lack of adequate health care in this country."
2. Such Government employees are using "coercive devices."
3. Bureaucrats in our National Government have been dispatched to Tokyo and Manila for the purpose of establishing programs of compulsory sickness insurance in the Philippines and Japan.

The first two points require no comment. As to the third, a United States health mission did go to Japan last year at the request of General MacArthur, who needed help in restoring Japanese health insurance from wartime disorganization. There was no need to establish such a system; it was established in Japan more than 20 years ago. The statement that such a United States mission was sent to Manila is a complete fabrication.

The NPC literature relies heavily on irresponsible statements by Representative Harness (Republican, Indiana), who, as head of a House subcommittee, has conducted a witch hunt among the half-dozen or so Government officials who really want to extend medical services, but who hold quite varying opinions on how this should be accomplished.

Harness is quoted in the fund-seeking propoganda sheets as saying "Known Communists within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard." The fact is, of course, that known Communists are taboo these days in Federal agencies.

The attempt of Harness to lay national health insurance on the unpopular Soviet doorstep entirely ignores the fact that some 35 countries now have such systems, including Great Britain, France, New Zealand, Mexico, Chile, Denmark, and Sweden.

The English health insurance plan was put into effect by that well-known Stalinist, Lloyd George, back in 1911.

The NPC crowd of verbal strong-arm men are hoping to intimidate President Truman into failing to reindorse this year, the long-pending Wagner-Murray-Dingell national health insurance bill.

They are doomed to disappointment.

The President will definitely urge national health legislation again in the budget message which he will send to Congress next month.

NPC attachment No. 4

National Physicians Committee for the Extension of Medical Service schedule of contributions—$500 or more year ended Dec. 31, 1947

Name of payor	Address	Amount
1. The Matline Co	New York, N. Y	$1,000
2. Eli Lilly & Co	Indianapolis, Ind	15,000
3. Abbott Laboratories	N. Chicago, Ill	10,000
4. Norwich Pharmacal Co	Norwich, N. Y	2,500
5. G. D. Searle & Co	5110 Chicago 80, Ill	1,000
6. Cutter Laboratories	Berkeley, Calif	2,000
7. Pitman-Moore Co	Indianapolis, Ind	500
8. Burroughs Wellcome & Co	New York, N. Y	1,500
9. McNeil Laboratories, Inc	Philadelphia, Pa	2,000
10. Smith, Kline & French Laboratories	do	2,000
11. Wm. R. Warner & Co., Inc	New York, N. Y	3,000
12. E. R. Squibb & Sons	do	10,000
13. Winthrop Chemical Co., Inc., now Winthrop-Stearns Co., Inc.	do	4,000
14. Bristol-Meyers Co	do	1,500
15. The Mentholatum Co	Buffalo, N. Y	500
16. The National Drug Co	Philadelphia, Pa	500
17. Mead Johnson & Co	Evansville, Ind	15,000
Total		72,000

National Physicians Committee for the Extension of Medical Service schedule of contributions—$500 or more 3 months ended Mar. 31, 1948

Name of payor	Address	Date received	Amount
Parke Davis & Co	Detroit, Mich	January-March	$7,500
Hoffman-La Roche, Inc	Nutley, N. J	do	5,000
American Cyanamid Co	Bound Brook, N. J	do	10,000
Winthrop-Stearns, Inc	New York, N. Y	do	4,000
Johnson & Johnson	New Brunswick, N. J	do	1,000
Wm. S. Merrell Co	Cincinnati, Ohio	do	500
The Upjohn Co	Kalamazoo, Mich	do	15,000
Burroughs Wellcome Co	New York, N. Y	do	500
Rexall Drug Co	Beverly Hills, Calif	do	7,500
Sharpe & Dohme	Philadelphia, Pa	do	2,500
Total			53,500

(Taken from Form A, filed with the Clerk of the House of Representatives by the National Physicians Committee as required by the Lobbying Act).

NPC attachment No. 5

[From the Journal of the American Medical Association, December 20, 1947]

Medical Services Foundation Dissolved

The board of the trustees of the Medical Services Foundation met in Chicago December 1. The members unanimously decided (a) to dissolve Medical Services Foundation and (b) refund to all contributors the full amounts of money paid into the treasury of Medical Services Foundation.

The members of the board of trustees are convinced that 1948 will prove to be the "year of decision." They are convinced that effectiveness in operation can be quadrupled by unifying the efforts through merging contributions from the industries and the professions.

The management committee of the National Physicians' Committee voted unanimously that the National Physicians' Committee should receive in its treasury all contributions tendered by members of the drug-manufacturing industry. Refund checks have been issued to all contributors to the Medical Services Foundation. More than 90 percent of the refunds made have been pledged to the National Physicians' Committee as contributions for 1947.

NPC attachment No. 6

[From the Washington Star, March 30, 1948]

ON THE OTHER HAND—AMERICAN MEDICAL ASSOCIATION'S ATTEMPT TO INFLUENCE CARTOONISTS

(By Lowell Mellett)

Something very interesting has been happening recently in the newspaper world and the public should be told about it. The newspapers have been too modest for the most part to do the telling, so here goes:

There appears in the February 28 issue of Editor and Publisher, trade journal of the newspaper business, a page advertisement submitted by the National Physicians' Committee for the Extension of Medical Service. The committee describes itself further as "a nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical service to all the people." Take particular note of the word "ethical," for this story has to do with ethics.

The advertisement is directed at newspaper cartoonists. It offers prizes ranging from $1,000 down to $100 for cartoons on the subject of socialized medicine. To be eligible for the contest the cartoons, of course, must appear in the newspapers for which the cartoonists work.

"Write for factual data," says the ad. "Write today for free package of supplemental data which already have been published by leading periodicals with the objective of:

"Preserving in the United States our system of freedom of enterprise to the end that—

"Doctors of medicine may retain, in the public interest, their personal independence, their individual and collective integrity and effectiveness.

"We shall be happy to send you additional brochures, articles, and reports of general information which will be helpful to you."

Only average intelligence is required to recognize this "contest" for what it is—a bald attempt to buy the support of America's cartoonists for the American Medical Association's fight against national health insurance. (The National Physicians' Committee is the propaganda arm of AMA.) Editor and Publisher, having at least average intelligence, followed through in its next issue with an editorial in which it said:

"The 'contest' rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs and to obtain general circulation for those beliefs in newspapers and magazines. In other words, large cash rewards are offered to cartoonists for doing a propaganda job in behalf of the Physicians' Committee. * * *

"They offer rewards for doing a slanted job in newspapers and magazines. And it will be difficult for any cartoonist or his editor to deny charges of critics that they were bribed by the $1,000 first prize into supporting the viewpoint of the Physicians' Committee, even though their opinion may have been arrived at independently."

That was the first evidence of a clash between journalistic ethics and the ethics of the American Medical Association—which are not exactly the same thing as medical ethics.

Other evidence was given by angry editorials in a few newspapers, although most newspapers have preferred to remain silent, not wishing to call attention to the fact that the AMA considers it possible to bribe editors and cartoonists. The best evidence perhaps was given by a cartoonist, Roy Justus, of the Minneapolis Star. He drew a cartoon but it was not what the doctors ordered. It was designed to burn the pants off the so-called Physicians' Committee. His paper printed it.

A few more incidents of this kind may cause the decent doctors of this country, meaning the majority, to take a serious look at what the AMA has been doing in their name.

[From the Washington Post, Friday, May 7, 1948]

PRESS BRIBERY

Senator James E. Murray rendered a service to two professions—medicine and journalism—in exposing last week the sordid propaganda tactics of the National Physicians' Committee, an undercover instrument of the American Medical Association. The committee sponsored a cartoon contest, offering eight prizes totaling $3,000 for the "best" cartoons attacking the idea of a national health-insurance program. As Editor and Published, journalistic trade paper, put it in commenting on the contest when it was first announced. "The 'contest' rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs (according to how you look at it) and to obtain general circulation for those beliefs in newspapers and magazines." The catch in the "contest" is the requirement that the cartoon must first have been published to receive consideration for an award.

It is improbable that any reputable cartoonist or newspaper will fall for this egregious insult to journalistic integrity. Its evil effects will be felt more by medicine than by the press. For the members of the AMA, an overwhelming majority of whom we are sure would take no conscious part in this attempt at corruption, are subject to its shame. Here is a form of malpractice which the doctors can best cure by excising its source. Their ideas and interests need better—and more honest—representation than they have received from the National Physicians' Committee.

[From Editor and Publisher, May 1, 1948]

SENATOR MURRAY FLAYS "VICIOUS" CARTOON PRIZES

WASHINGTON.—Senator James E. Murray, of Montana, told the Senate this week that the National Physician's Committee of Chicago has attempted "the most flagrant and vicious attempt to undermine the press of America which I have come across for many years" and gave "everlasting credit" to Editor and Publisher for leadership in making "such trickery impossible in the future."

The Montanan displayed a full-page advertisement from the February 28 issue of Editor and Publisher, in which the committee offered eight prizes totaling $3,000 for the best cartoons depicting—in the committee's own language—"the meaning and implications of political distribution of health-care services in the United States."

Senator Murray, author of a pending national-health bill, declared the real purpose of the contest was made clear by republication of a cartoon against socialized medicine which appeared years ago in the Chicago Tribune.

Recounting that a cartoon to be eligible for prize consideration must first have been printed in some newspaper or syndicate feature, the Senator cited "one bright feature" by stating:

"It is to the everlasting credit of Editor and Publisher, perhaps the leading magazine in the field of practical and effective journalism, that it accepted the National Physician's Committee's full-page advertisement of a fake prize contest—through which the bribe was offered—and then ran an editorial which denounced the ad as an attempt at bribery, and which called on the American Society of Newspaper Editors for a revision of the Canons of Journalism to make such trickery impossible in the future."

Senator Murray charged that the committee is the political lobby and propaganda bureau of the American Medical Association. Discussing its methods, the Montanan said of the committee:

"Over the past 6 years it has admittedly spent over a million dollars in its propaganda efforts. It has flooded the country with more than 25,000,000 pamphlets and circulars, including handouts in the large drug stores. It has arranged for publication of more than 3,000 full-page advertisements in newspapers. It has swamped newspapers with everything from carefully angled 'news' stories to pretendedly forthright, carefully written editorials which an editor is free to run as an expression of his own. It has made wide use of radio, direct mail solicitation, education, and every other known technique of public relations, including the direct lobbying of United States Senators and Representatives here in Washington."

[Reprinted with permission from Public Relations News, New York]

PUBLIC RELATIONS NEWS

(The only weekly public relations publication for executives)

Letter No. 197, April 19, 1948

One of the most unethical public relations programs from the point of view of publishing ethics has been launched by National Physicians' Committee for the Extension of Medical Service. The committee is fighting the Murray-Wagner-Dingell bill in Congress. It offers $3,000 in prizes to newspaper and magazine cartoonists for published cartoons portraying "the meaning and implications of political distribution of health care services in the United States."

Slice it as you like, this is a bribe to the cartoonists of America to lend their talents and sway the attitude of their publishers in support of a medico-political project. The committee couldn't have picked a better way to arouse the contempt of cartoonists and the indignation of editors and publishers. It is about time those who devise such campaigns learned that newspaper reporters, editors and cartoonists are not bootlickers who can be bribed to pervert editorial integrity whether cash or Scotch is the bait.

NPC attachment No. 7

[From the Congressional Record]

EFFORTS TO UNDERMINE THE PRESS

(Speech of Hon. James E. Murray of Montana in the Senate of the United States Monday, April 26, 1948)

Mr. MURRAY. Mr. President, I should like to take a few moments to discuss what I consider one of the most flagrant and vicious attempts to undermine the free press of this country that I have come across for many years. This attempt was made in two ways. One was out-and-out bribery of American newspaper cartoonists. The second was a despicable set of lies, addressed to the editors of this country, regarding the National Health Assembly, which meets in Washington May 1 to May 4, 1948.

The culprit is the so-called National Physicians Committee—a notorious and disgraceful lobby managed by a few highly paid public relations men who, through misrepresentation, annually extort hundreds of thousands of dollars from physicians and drug houses. In the past, this organization has been repeatedly guilty of using the vicious Hitler-Stalin tactic of the great lie—for example in labeling as communistic legislation endorsed by two Presidents of the United States and sponsored by six Members of the United States Senate, four of whom are also members of that church which is perhaps communism's greatest enemy. Despite the fact that it was dealing with matters literally involving life and death, the National Physicians Committee has spent over a million dollars in appeals to fear and hate, but not a nickel on appeals to reason.

Now, to the everlasting shame of thousands of honest and conscientious doctors throughout the country, this depraved group, in their names, has reached a new low and is attempting to bribe the cartoonists of America and thereby to buy the editorial opinions of the Nation's press.

It is to the everlasting credit of Editor and Publisher, perhaps the leading magazine in the field of practical and effective journalism, that it accepted the National Physicians Committee's full-page advertisement of a fake prize contest, through which the bribe was offered, and then ran an editorial which denounced the advertisement as an attempt at bribery, which called on the American society of newspaper editors for a revision of the canons of journalism to make such trickery impossible in the future.

I have here a copy of the full-page advertisement I referred to. It was published in the February 28 issue, Editor and Publisher. It is signed by the National Physicians Committee of Chicago, Ill.

The advertisement announces the offer of 14 cash awards to newspaper cartoonists for the most effective portrayal "of the meaning and implications of political distribution of health-care services in the United States."

The top prize is $1,000, and eight other awards range from $500 to $100.

Despite the obscure phrasing of the basis of these awards, the purpose is obvious. What the committee is looking for—and what it will distribute the prize money for—is published cartoons attacking the principle of national health insurance.

To make this purpose crystal clear, so there will be no possible misunderstanding, the advertisement reprints a sample cartoon, published some years ago by J. M. Darling, otherwise known as "Ding."

This cartoon shows Congress in the guise of an unattractive old biddy pouring out a dose of medicine to be administered to the poor long-suffering public. The medicine is labeled "Socialized Medicine—$3,000,000,000 a Bottle." The frightened Mr. Public is being held tightly in the grasp of a gentleman labeled "Political Quack." In the foreground is another gentleman, labeled "Medical Science" who is depicted as having been bound and gagged—in other words, helpless to prevent the outrage. And in the background is a group of mourners gathered around the coffin of an admittedly able citizen, now presumably deceased, labeled "Free enterprise."

At the top of the cartoon is the caption, "It is all mixed and ready to swallow."

I have no quarrel with Mr. Darling or with his right to present his own views through his syndicated cartoon strip. From a purely objective viewpoint I can even admire the skill with which he managed to compress into one picture all the prejudices and fears of those vested interests which are arrayed against this proposed legislation.

What I do object to is this outrageous and cynical attempt, on the part of the National Physicians Committee, to bribe the cartoonists of America into helping them spread their propaganda. No matter what opinion any member of this honorable body may hold as to the merits of the legislation involved, I know that each of my colleagues will join me in condemning this vicious, underhanded attempt to buy the free editorial-cartoon expression of the newspapers of this country.

Do not make any mistake. In spite of the risk of possible flare-backs which such a campaign of chicanery may engender, this method of poisoning the wells of public opinion is extraordinarily and insidiously clever. No self-respecting newspaper cartoonist would countenance an outright effort to offer him a bribe. He would reject indignantly any attempt to slip him, say, $50 for putting across a cartoon angled to meet the requirements of some special interest. But a prize contest is, psychologically, something else again. On the surface it is all open and above-board. By the terms of the conditions, he could even submit a cartoon in favor of so-called socialized medicine—that is, if he were naive enough to believe that such an entry would be given a moment's consideration.

I say it may seem open and above-board. But the real catch in this contest—now, get this—is the requirement that the cartoon, to be entered, must first have been published in some newspaper or syndicate feature. The committee makes sure that the cartoon achieves its normal circulation before it is even judged.

There is probably many a hard-pressed cartoonist, sitting hunched over his drawing board, trying to dig out an idea for tomorrow's paper, who might grasp at this ready-prepared subject as a means of meeting a deadline. Moreover, like lots of the rest of us, he might well be worried over money. Who could not use an extra thousand—or even an extra hundred?

This latest and most outrageous attempt to exert undue influence on public opinion focuses attention once again on this highly questionable National Physicians Committee. The full name of this group is the National Physicians Committee for the Extension of Medical Services. It describes itself as a "nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical services to all the people."

It calls itself nonpolitical, yet is registered under the Lobbying Act. It calls itself nonprofit, but the three laymen running it profit to the tune of 10 to 14 thousand dollar a year salaries, plus apparently unlimited expense accounts. It calls itself a physicians committee, but its list of contributors of $500 or more submitted under the Lobbying Act sets forth the names of some 14 drug manufacturers, but does not include that of a single physician. It says its purpose is to extend medical services to all the people, but its record shows over a million dollars spent in opposing health legislation, and not a penny spent or an action taken which extended medical care to anyone.

From behind all this pious verbiage emerges the blunt fact that the committee is the political lobbying and propaganda bureau of the American Medical Association—and that its chief purpose today is the blocking of any legislation aimed at the extension of medical services under a system of national health insurance.

Over the past 6 years this committee has admittedly spent over a million dollars in its propaganda efforts to accomplish this end. It has flooded the country with more than 25,000,000 pamphlets and circulars distributed through every conceivable channel, including over-the-counter hand-outs in the large drugstore chains. It has arranged for the publication of more than 3,000 full-page advertisements in various newspapers throughout the country. It has swamped newspapers and other periodicals with everything from carefully angled news stories to pretendedly forthright carefully written editorials which an editor is free to run as an expression of his own views. It has made wide use of the radio, direct-mail solicitation, education, and every other known technique of public relations, including the direct lobbying of United States Senators and Representatives here in Washington.

This cartoon-prize award stunt is merely the latest example of the committee's consummate skill in publicity methods. It is apparently a forerunner of the campaign which has been scheduled for this year and for which, I am informed, the committee is planning to spend some $600,000—or double the amount spent in 1947.

Some of this money is undoubtedly contributed by physicians who perhaps believe that the inauguration of a system of national health insurance will damage their own pocketbooks. But tens of thousands of dollars, by the admission of the committee itself, have been contributed by the great pharmaceutical manufacturers and other interests allied to the drug and medical fields.

I cannot believe that these manufacturers are opposed to a health-insurance program which would make medical care available to many more people than can now afford it. After all, even from a purely selfish point of view, these men must realize that more people getting more medical care means more drugs sold. One is forced to wonder whether it can be the power of the politicians of organized medicine to endorse or withhold endorsement of drug products which accounts for these contributions by reputable manufacturers to so odious an outfit.

This National Committee of Physicians was organized originally to take over the publicity and propaganda activities of the American Medical Association at a time when it was feared that such activities might undermine the tax-exempt status of the parent organization. Many reputable doctors—members of the AMA—have protested the right of this committee to assume these functions. They charge it with being an irresponsible clique which, by its ruthless and scurrilous attacks on all proponents of national-health insurance, is putting not only the AMA but all honest medical practitioners in bad odor with the American people.

The basic line of attack of this propaganda is quite simple. It is to smear the whole project as socialized medicine, relying on the effect of that horrendous word "socialism" to scare ordinary minded citizens away. Not content with this snide attack, they are now labeling the proposal out-and-out communistic. Riding the wave of our present international difficulties, they are working the "Red menace" for all it is worth.

National health insurance, they tell us, is a project conceived by the Kremlin and fostered by Communist Reds and fellow travelers in this country for the sole purpose of inserting an entering wedge for the overthrow of our democratic system of government. Any person who supports the project is pro-Stalin and anti-American. Any person who opposes it is a stanch defender of private enterprise and the American way of life.

I do not have to state my own profound conviction about democracy and the American way of life to resent this cheap, mendacious appeal to emotionalism and insult to the intelligence of the American public.

I have no present intention of discussing the merits of the bill, as such. I recognize that there exist many honest differences of opinion as to the advisability of enacting such legislation. But while I am on the subject, I should like to draw attention to the smear attack now being unleashed by this same national physicians committee against the projected National Health Assembly which is to meet here in Washington on May 1.

This National Health Assembly, as Senators all know, has been called by the Federal Security Administrator, Oscar R. Ewing. The purpose of the assembly is to develop a concrete plan for increasing the health safeguards of this Nation over the next 10 years. It will be attended by some 700 to 800 representatives of public and private organizations and agencies concerned with various phases of the Nation's health. Its executive committee comprises leaders in the several fields involved, including a number of eminent physicians and other outstanding leaders in the health field.

There is no one in touch with the many pressing problems of public health in this country who does not recognize the vital necessity of making an expert appraisal of our needs and of laying down a concrete program of action.

Among these are:

The problem of sanitation—of improved water supply and sewerage systems for our towns, cities, and rural areas.

The necessity for more hospitals and medical centers to serve the needs of our population.

The lack of adequate personnel in our public-health services, and the crying need to train thousands more doctors, dentists, nurses, laboratory technicians. The problem of what to do about the startling fact that 8,000,000 Americans are today suffering from some form of mental or nervous illness.

The always present problem of school health and the need of expanding regular health examinations, medical treatment, and physical education services for the benefit of our children.

Then there are the vocational rehabilitation services, the maternal and child-health services, the services for crippled children, and many other problems.

These are among the major topics for discussion which appear on the agenda which has been drawn up for the assembly. By common consent they are noncontroversial matters, that is to say, they involve areas of activity which most responsible physicians and public-spirited citizens agree should be further explored.

Certainly, to the health and well-being of the 145,000,000 American men, women, and children they are matters of the greatest importance, and any honest attempt, by a responsible group of citizens, to meet the challenge of these problems should be given every encouragement and support.

But what do our friends the National Physicians Committee say to all this? In a canned editorial, for distribution among newspaper editors all over the country, they lash out at it as a politically inspired move on the part of the President—engineered by what they describe as his extreme leftist advisers—to strengthen his position in the 1948 campaign. Ignoring the clearly stated intent of the assembly, they insinuate that its only objective is to push forward the administration's program of so-called socialized medicine. To their bigoted and narrow minds it can have no other purpose.

As proof of their contention, they point out that both President Truman and Federal Security Administrator Ewing are on record in favor of national health insurance. They charge the Federal Security Administration, which is sponsoring the assembly, as being, in its study division the "nerve center of socialized medicine propoganda for the entire world." And they interject downright lies—or at least totally misleading statements—concerning the experience of Great Britain in implementing a similar system.

I do not have to point out that the findings arrived at on this controversial subject of national health insurance by the study division of the FSA were based on hard, laborious, and objective research—and that, despite attack, they have been substantially accepted not only by many prominent physicians, but by such representative leaders as Bernard Baruch, Bishop Francis J. McConnell, Mrs. Eleanor Roosevelt, and Gerard Swope.

By dragging the red herring of Socialist-inspired—or Communist-inspired—national health insurance across the trail of this assembly, the National Physicians Committee reveal themselves as opposed to any rational attempt to improve the Nation's health so long as this attempt is sponsored by the Government. Their cry of free enterprise, as it involves their own profession, is employed to scotch every effort toward liberal reform.

Because of its immoderate activities, this committee has been called one of the most reactionary elements in our entire national economy—and with its powerful propaganda and lobbying machine, one of the most dangerous.

I think that has now been clearly demonstrated. But in order to destroy any possibility that Senators on the other side of the aisle might think my remarks tinged with partisanship, let me quote another characterization of the National Physicians Committee:

"The National Physicians Committee has supplied the medical profession and the public with sheer buncombe * * * its publications are misleading * * * it is an inimical force working against the medical profession from within."

Those statements were made, Mr. President, not by a proponent of national health insurance, but by Dr. Shearon, the expert on medical care matters employed by the Republican National Committee.

I hope the people of this country, together with all newspaper editors and radio commentators, will appraise the national health assembly, convening May 1, for what it actually is—and not what these reactionary elements claim it to be.

I hope they will appreciate that it is not called merely to put its seal of approval on a program already determined by the Government, but that it is a meeting of recognized authorities in the field of medical and health services—few of whom have any political ax to grind—and that the sole purpose of these authorities is to lay out a practical and comprehensive program for improving this Nation's health, over the next 10 years, based on their own individual knowledge and experience.

I think it is highly to the credit of this administration that it has sponsored the calling of this assembly. I think it has been wise in its decision to allow whatever program is formulated to be developed from the grass roots for the grass roots of this country, by those who are closest to the actual situation.

I repeat, Mr. President, I think it is to the everlasting shame of thousands of honest, conscientious, social-minded doctors throughout the land that they permit this vicious so-called National Physicians Committee to continue its activities—and to create the impression that the medical profession of this Nation is opposed to any progress in the domain of this country's public health.

In closing, Mr. President, I ask unanimous consent that the three excerpts from the magazine Editor and Publisher which I hereby submit, together with an article by Lowell Mellett from the Washington Star, be printed in the Record at the close of my remarks.

There being no objection, the matters were ordered to be printed in the Record, as follows:

[From Editor and Publisher of February 28, 1948]

ANNOUNCING CASH AWARDS FOR CARTOONISTS—FOURTEEN IMPORTANT AWARDS

Over a period of years, it has been our privilege to reprint many cartoons portraying artists' appraisal of the political distribution of medical care in the United States. One of these cartoons appears in this announcement.

Any cartoonist regularly employed by any newspaper or magazine of general distribution or by any syndicated service is eligible to submit exhibits to be judged for the awards.

First award	$1,000
Second award	500
Third award	250
Fourth award	200
Fifth award	150
Sixth to ninth awards (each)	100

BASIS OF AWARDS

Judging will be based solely on originality and effective portrayal of the meaning and implications of political distribution of health-care services in the United States.

FOLLOWING ARE THE RULES

1. Entrants must submit 10 copies of publication in which the cartoon has been published, with a letter of formal application approved by his publisher.
2. Full permission must be granted by publisher to reprint the cartoon submitted.
3. Six copies of engravers' proofs of original illustration must be provided.
4. The period of this effort will be March 1 to May 31, 1948. Wherever editorial dead line is prior to April 1, artists may submit advance proofs of publication with statement from publisher that the cartoon is to be published on a specific date.
5. All exhibits submitted must be postmarked before midnight, May 31, 1948, and must be mailed or delivered to twenty-first floor, Lincoln Tower Building, Chicago, Ill. Entrants may submit as many published cartoons as they desire.

6. Judges will comprise a group of nationally known publishers and editors. Decision of judges will be final. In case of ties, duplicate awards will be made. No individual cartoonist shall be eligible for more than one award.

7. In addition to cash awards listed above, an appropriate parchment scroll, award of merit, will be given to each winner.

WRITE FOR FACTUAL DATA

Write today for free package of supplemental data which already have been published by leading periodicals wtih the objective of preserving in the United States our system of freedom of enterprise to the end that doctors of medicine may retain, in the public interest, their personal independence, their individual and collective integrity and effectiveness.

Your understanding of purpose is sought and cooperation is welcomed in the belief that joint efforts may result in the attainment of these objectives.

We shall be happy to send you additional brochures, articles, and reports of general information which will be helpful to you.

National Physician's Committee for the Extension of Medical Service.

Chicago, Ill.

A nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical service to all the people.

[From Editor and Publisher of March 6, 1948]

Questionnaire Contest

The National Physicians' Committee for the Extension of Medical Service, an organization opposed to the Murray-Wagner-Dingell bill, and other like measures, is offering $3,000 in prizes to newspapers and magazine cartoonists for their "portrayal of the meaning and implication of 'political distribution of health care services in the United States.'" An ad announcing this contest wtih $1,000 first prize appeared in Editor and Publisher last week.

Completely ignoring the political viewpoint of this committee, which it is not our function to criticize or evaluate, let us analyze the contest.

First, the rules make it clear that no cartoon will qualify for one of the fourteen cash awards unless it takes a position against the proposed bill. A "Ding" Darling cartoon, printed in the ad lampooning "Socialized Medicine," serves as a guide.

Second, proof of publication is required to enter the "contest."

The contest rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs (according to how you look at it) and to obtain general circulation for those beliefs in newspapers and magazines. In other words, large cash rewards are offered to cartoonists for doing a propaganda job in behalf of the physicians' committee.

We classify this contest with those photography contests which require cameramen to portray certain products in their published photos—cigars, coffee, etc.—in order to qualify for an award. They are all a threat to independent thinking, objective and unbiased reporting and comment in newspapers.

They offer rewards for doing a slanted job in newspapers and magazines. And it will be difficult for any cartoonist or his editor to deny the charges of critics that they were bribed by the $1,000 first prize into supporting the viewpoint of the physicians' committee, even though their opinion may have been arrived at independently.

The American Society of Newspaper Editors, and all editors' groups, should take a firm stand against such contests. The Canons of Journalism should be amended to require that all newspapermen ignore the cash rewards offered in so-called contests in which qualification is based on getting mention of a product or one side of a controversial political subject into the paper.

[From Editor and Publisher of March 13, 1948]

A Vicious Attempt To Bribe the Press

To the Editor:

Now comes the National Physicians' Committee for the Extension of Medical Service with an attempt to bribe the American press by offering $2,200 in prize money to newspaper cartoonists, as revealed in an advertisement on page 27 of Editor and Publisher for February 28. What an insult. Does this selfish group think American cartoonists can be bought—and for such a paltry list of prizes?

This is the boldest, most insidious, most vicious attempt to infiltrate selfish ideas into the American press that has occurred in recent years.

The committee offers cartoonists a "free package" of supplemental data which will furnish ideas. And look what they expect to get for 2,200 bucks; "ten copies of the publication in which the cartoon has been published with a letter of formal application approved by the publisher" * * * "full permission must be granted by the publisher to reprint the cartoon submitted." Here the committee reveals its purpose—to have original cartoons opposing socialized medicine published extensively in American newspapers.

The advertisement referred to was illustrated by a cartoon by J. N. Darling, titled "It's All Mixed and Ready to Swallow," showing Congress in the character of mother pouring from a bottle labeled "Socialized Medicine, three billion a bottle" into a gigantic spoon for administration to a pitiful little figure labeled "Public" held on the floor by a "Political Quack" while "Medical Science" lies in the foreground, bound and gagged. In the background a group of mourners weep over the bier of "Free Enterprise."

No one questions the right of Mr. Darling to draw this cartoon if it expresses his convictions, nor the right of a newspaper to publish it for the same reason. No one questions the right of the committee to argue its side of this great issue in paid advertisements and such other means as may be available to it. Everyone who understands the purpose of a free press in a democracy will deny the right of the committee thus to attempt to corrupt the press.

I don't believe there is a single newspaper cartoonist anywhere in the United States who will fall for this sordid scheme. On the contrary, I believe it will stir the resentment of every cartoonist, editor, and newspaper worker, and I hope the American newspapers will expose this attempt to subvert their true functions.

Criticisms of American newspapers have been numerous and loudly vocal in recent years. This is an opportunity for American newspapers to show that sometimes when a newspaper slips up, the original blame belongs to some selfish institution or group. The public should know the terrific pressures by pressure groups upon every editorial staff every day in the year, and here is a concrete example.

RALPH L. CROSMAN,
Director, College of Journalism, University of Colorado.

BOULDER, COLO.

[From Editor and Publisher of March 20, 1948]

TO EDITORS FROM DOCTORS

We congratulate Editor and Publisher for its forthright editorial in the March 6 issue condemning the contest announced by the National Physicians' Committee in its full-page advertisement which had appeared in Editor and Publisher a week earlier. This advertisement offered $3,000 in prizes to newspaper cartoonists for portrayal of the meaning and implications of political distribution of health-care services in the United States.

The editorial stated clearly the unethical character of the advertisement thus: "The 'contest' rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs (according to how you look at it), and to obtain general circulation for those beliefs in newspapers and magazines. In other words, large cash awards are offered to cartoonists for doing a propaganda job in behalf of the physicians' committee. * * * They (such contests) are all a threat to independent thinking, objective and unbiased reporting and comment in newspapers. They offer rewards for doing a slanted job in newspapers and magazines."

Some readers may have been surprised at this attempt by the National Physicians' Committee to pervert journalism. Unfortunately we were not surprised. We were ashamed. We as physicians have long been ashamed of the National Physicians' Committee, because it has conducted a propaganda campaign with disregard for facts and a readiness to employ odious labels in place of reasoned argument.

The name, National Physicians' Committee, may cause many laymen to assume that it speaks for all members of the medical profession. This is emphatically not so. Many physicians are opposed to the aims and purposes of the National Physicians' Committee, and many more are ashamed of the methods it constantly uses.

The committee has misrepresented the national health legislation which it opposes. In the official record of the Senate hearings in 1946, for example (December 1, 1945, pp. 963–968), seven of the committee's statements regarding the bill were shown to be false by comparing them with the summary of the bill published in the Journal of the American Medical Association. The American Medical Association opposed the bill, but printed a factual analysis of it.

The committee has sent to all physicians of the country—and we believe also to many newspapers and periodicals—statements to the effect that the national health-insurance legislation grows out of collectivist doctrine and emanates from Moscow, despite the fact that the principle of this legislation is supported by such Americans as the President of the United States, Mr. Bernard M. Baruch, and the officers of the committee for the Nation's health named below.

We are informed that the National Physicians' Committee has for some time made a practice of distributing canned editorials on a national scale. Some newspapers have published these opinions as their own. Now the National Physician's Committee proposes the cartoon contest which has been so justly condemned. We are glad that Editor and Publisher calls upon the men in the profession of journalism to take a firm stand against such contests. We hope that in the future the literary products of the National Physicians' Committee, whether submitted as editorials, news, or advertisements, will be given close scrutiny as to their factual and ethical basis.

We physicians, as members of a scientific profession, want to see this subject of medical care handled in a scientific spirit and according to ethical principles which the best men in our profession and in yours have the privilege to cherish.

Thomas Addis, M. D., San Francisco; Ernst P. Boas, M. D., New York; Allan M. Butler, M. D., Boston; Paul B. Cornely, M. D., Washington; Katharine Dodd, M. D., Cincinnati; Channing Frothingham, M. D., Boston; Harry Goldblatt, M. D., Los Angeles; John V. Lawrence, M. D., St. Louis; Hyman Morrison, M. D., Boston; John P. Peters, M. D., New Haven; Henry B. Richardson, M. D., New York; Harry Saltzstein, M. D., Detroit; Max Seham, M. D., Minneapolis; Edward L. Young, M. D., Boston.

(This advertisement is paid for by the Committee for the Nation's Health, 1709 Broadway, New York, a nonpartisan organization supporting national health insurance. Chairman, Channing Frothingham, M. D., honorary vice chairmen, Jonathan Daniels, Russell Davenport, William Green, Bishop Francis J. McConnell, Philip Murray, Bishop G. Bromley Oxnam, Mrs. Franklin D. Roosevelt, David Sarnoff, Gerard Swope. Directors, Thomas Addis, M. D., Barry Bingham, Ernst P. Boas, M. D., Morris Llewellyn Cooke, John J. Corson, Mrs. Gardner Cowles, Michael M. Davis, Albert W. Dent, Abe Fortas, Channing Frothingham, M. D., Mary Dublin Keyserling, Carl C. Lang, Mrs. Albert D. Lasker, John V. Lawrence, M. D., Dorothy Norman, Emil Rieve, Anna M. Rosenberg, V. Henry Rothschild 2d, R. M. Walls, D. D. S., Matthew Woll.)

[From the Washington Star of March 30, 1948]

American Medical Association's Attempt to Influence Cartoonists

(By Lowell Mellett)

Something very interesting has been happening recently in the newspaper world and the public should be told about it. The newspapers have been too modest for the most part to do the telling, so here goes:

There appears in the February 28 issue of Editor and Publisher, trade journal of the newspaper business, a page advertisement submitted by the National Physicians' Committee for the extension of medical service. The committee describes itself as a nonpolitical, nonprofit organization for maintaining ethical and scientific standards and extending medical service to all the people. Take particular note of the word "ethical," for this story has to do with ethics.

The advertisement is directed at newspaper cartoonists. It offers prizes ranging from $1,000 down to $100 for cartoons on the subject of socialized medicine. To be eligible for the contest the cartoons, of course, must appear in the newspapers for which the cartoonists work.

"Write for factual data," says the ad. "Write today for free package of supplemental data which already have been published by leading periodicals with the objective of:

"Preserving in the United States our system of freedom of enterprise to the end that—

"Doctors of medicine may retain, in the public interest their personal independence, their individual and collective integrity and effectiveness.

"We shall be happy to send you additional brochures, articles, and reports of general information which will be helpful to you."

Only average intelligence is required to recognize this contest for what it is—a bald attempt to buy the support of America's cartoonists for the American Medical Association's fight against national health insurance. (The National Physicians' Committee is the propaganda arm of AMA.) Editor and Publisher, having at least average intelligence, followed through in its next issue with an editorial in which it said:

"The contest rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs and to obtain general circulation for those beliefs in newspapers and magazines. In other words, large cash rewards are offered to cartoonists for doing a propaganda job in behalf of the Physicians' Committee. * * *

"They offer rewards for doing a slanted job in newspapers and magazines. And it will be difficult for any cartoonist or his editor to deny charges of critics that they were bribed by the $1,000 first prize into supporting the viewpoint of the Physicians' Committee, even though their opinion may have been arrived at independently."

That was the first evidence of a clash between journalistic ethics and the ethics of the American Medical Association—which are not exactly the same thing as medical ethics.

Other evidence was given by angry editorials in a few newspapers, although most newspapers have preferred to remain silent, not wishing to call attention to the fact that the AMA considers it possible to bribe editors and cartoonists. The best evidence perhaps was given by a cartoonist, Roy Justus, of the Minneapolis Star. He drew a cartoon but it was not what the doctors ordered. It was designed to burn the pants off the so-called Physicians' Committee. His paper printed it.

A few more incidents of this kind may cause the decent doctors of this country, meaning the majority, to take a serious look at what the AMA has been doing in their name.

NPC attachment No. 8

[Western Union night letter]

June 8, 1947.

Dr. H. H. Shoulders,
President, American Medical Association,
Atlantic City, N. J.:

The appeal for funds broadcast to physicians throughout the country by the National Physicians' Committee and which I have just seen, demonstrates that this propaganda arm of the American Medical Association is continuing its campaign of misrepresentation and prejudice. Asking doctors for contributions to fight the national health-insurance bill, the committee slanderously declares that a bill which has twice received the public endorsement of the President of the United States, which has been introduced by six United States Senators and two Representatives, and which is endorsed by organizations representing millions of American citizens is, "the collectivistic—the Soviet method" threatening our American way of life and the status of the medical profession.

The President of these United States and such thoroughly American men as Senators Wagner, Pepper, Chavez, Taylor, and McGrath, Representatives Dingell and Celler as well as myself have not and never will sponsor legislation that is anything but American in motivation, in form, and in content. I am and I believe your members will be thoroughly indignant at this vicious, false, and completely unjustified characterization of the national health-insurance bill and, indirectly, of its sponsors.

I ask you to also note the fact that on the letterhead under which its appeal for funds was made, the National Physicians Committee masquerades as "a nonpolitical organization for maintaining ethical and scientific standards * * *."

Public reports of this committee show that it has expended at least a million dollars, of which $300,000 was used during the last 5 months of 1946 when the Congress was not in session.

The National Health Insurance Act has been carefully drawn to maintain the independent status of physicians and of the organized medical profession. It assures free choice of doctor by patient. It guarantees doctors the right to share, with representatives of the people who pay the bills and receive the services, in managing the health-insurance fund and the operation of health insurance in every locality. It guarantees not only State but local direction of plans. It does not centralize control in Washington. Its history goes back to a compulsory health-insurance measure passed in 1798 by the Congress to protect the health of our own young Nation's merchant seamen. It is an American product framed by Americans to meet one of America's most pressing needs.

Doctors and laymen may have different opinions about the details of any plan devised to meet the demand of the American people that good medical services shall be available to all. The medical profession is especially entitled to share with the public in working out these differences of opinion, but through honest and free discussion and not through NPC appeals to fear and prejudice based on misstatements and the use of hate-inspiring words.

Dr. Marjorie Shearon, expert consultant to Senators Taft, Smith, and Donnell on health matters, has stated "the NPC has supplied the medical profession and the public with sheer buncombe * * * its publications are misleading * * * it is an inimical force working against the medical profession from within."

The sponsors of national health insurance legislation ask the American Medical Association and its members to repudiate, instead of supporting this utterly unfair and un-American organization and its campaigns based on distortion and emotion.

I ask that this telegram be read to the house of delegates in order that it may have an opportunity to take action regarding the National Physicians Committee which will be consistent with those century-old traditions of the association—the traditions which have won the deserved respect of the American people in the field of medical science.

James E. Murray,
United States Senator.

The AMA Can't Afford Blue Cross!

STATEMENT OF HON. JAMES E. MURRAY

Many witnesses representing medical societies have repeatedly told us that the voluntary hospital plans and voluntary medical society plans would meet the people's need for health insurance. The Blue Cross hospitalization program has been particularly singled out as exemplifying a most successful development.

I sincerely wish that voluntary plans could solve the problem. I am afraid the evidence indicates otherwise. The attached article by General Hawley, former director of VA's medical-care program and now in charge of the combined hospital and medical society plans, lends emphasis to my belief. In particular one recent development leads me to believe that General Hawley's hope that Blue Cross and Blue Shield can solve the problem in 3 years is unfortunately doomed to disappointment.

That development is to be found in the American Medical Society's cancellation of the Blue Cross contract covering its own Chicago employees. The AMA has told us and the people that they could solve their hospitalization problem by joining the Blue Cross. The AMA is worth millions, yet the AMA canceled its Blue Cross contract because the Blue Cross could not guarantee that it would not raise its rates. If the AMA with all its wealth cannot afford to join Blue Cross, how can those millions of our people whose incomes have not been able to keep pace with rising prices?

[New York Times, June 1, 1948]

SEES HEALTH PLANS ON A 3-YEAR TRIAL—DR. HAWLEY, BLUE CROSS-BLUE SHIELD EXECUTIVE, SAYS FAILURE MAY MEAN UNITED STATES PROGRAM

CHICAGO, May 31.—Some kind of health insurance is inevitable, and unless voluntary prepaid health plans meet the demand within the next 3 years, large labor organizations will press for a program of compulsory Government health insurance. This assertion was made here tonight by Dr. Paul R. Hawley, chief executive officer of the Blue Cross-Blue Shield commission.

He addressed a joint meeting of the country's three leading nursing associations, which are sponsors of the 5-day biennial nursing convention that opened here today. More than 10,000 registered nurses are attending. The sponsoring organizations are the American Nurses Association, the National League of Nursing Education, and the National Organization for Public Health Nursing.

The National Health Assembly, held in Washington May 1 to 4, made clear the inevitability of health insurance, leaving only the question whether it would be voluntary or a compulsory Government program, Dr. Hawley said. He formerly was chief medical director of the Veterans' Administration.

LEGISLATION MAY BE SOUGHT

"Spokesmen for influential groups issued the clear ultimatum that unless voluntary prepayment plans met their every need for medical care, and this in the very near future, they would press for legislation for a Government program," he declared.

"I believe firmly that the voluntary plans have not more than 3 years in which to meet these demands."

He summarized under these three groupings "the demands of large labor organizations":

1. Complete medical care. "Voluntary plans were criticized as being too limited in scope as regards the treatment of illness, and entirely lacking in preventive service" to the individual.
2. Removal of income limits. Most Blue Shield (medical care) plans place an upper limit on subscriber income, with those earning more being subject to additional charges by physicians.
3. Uniform coverage throughout the country, with a single contract. "Unions are insistent upon negotiating medical care at the national level."

REPUBLICAN GOVERNOR WARREN ON HEALTH INSURANCE

I am pleased to submit for the record the attached article by Republican Governor Warren explaining the reasons why he advocates a system of compulsory health insurance for his State of California. I believe those who have sat through these hearings and heard the proponents of national health insurance vilified as dupes and unconscious agents of a foreign ideology will find Governor Warren's retort to such attacks peculiarly effective.

For many years now the cosponsors of national health insurance have heard themselves labeled Socialists and Communists. Now that Republican Senator Taft has been labeled a Socialist because he has introduced a housing bill and Republican Governor Warren has also been labeled a Socialist and a Communist because he has advocated a new way of coping with a most real and serious problem we no longer feel so lonely. To defenders of the status quo—no matter how bad that status quo may be—all of us who attempt to work with the people to solve their problems are now agents of a foreign ideology. To such absurd lengths has this labeling now gone that its lack of meaning must be apparent to all.

Governor Warren and I disagree regarding details of a health insurance plan. But we are in complete agreement on the fact that health insurance will solve the problem and that with mutual sincerity and good will the details can be worked out.

[From Look, June 22, 1948]

MY PLAN FOR HEALTH INSURANCE—IT MAY MAKE THE GOLDEN STATE THE FIRST TO BANISH THE RUINOUS COST OF SERIOUS ILLNESS

(By Gov. Earl Warren, of California, as told to Nat S. Finney, 1948 Pulitzer prize winner)

For the past 5 years I have been trying to find a way for ordinary California families to keep themselves from going broke when serious illness strikes some one in their homes. I have had a lot of encouragement from husbands and wives who know from their own human experience how a huge wad of unexpected doctor and hospital bills can wreck a lifetime of frugal planning. I have also had a lot of discouragement from groups that push aside the simple, human catastrophe of serious illness and see only the reasons why nothing much can be done about it.

I am convinced the people of my State want a plan that will protect ordinary families from being wrecked by the costs of serious illness. Any plan that is fair and that will do the job will be accepted.

PLAN TO GUARD FAMILY NEST EGG

Any change that will improve a plan either before or after it is adopted will be welcomed. I would not object if the date on which a plan goes into effect is set far enough ahead to give the medical and hospital facilities of California time to make fully ready for it. My mind is open as to the details. It will not be closed until the ordinary family can look at the family nest egg without fear that serious sickness may gobble it up next day or week or month.

I often wonder just how many people even in California are clear in their own minds about what I have proposed to do. A blizzard of propaganda has hidden the simple facts about my proposal—about what the plan is and what it is not. Certainly the American people as a whole do not know how we propose in California to become the Nation's first State to solve this problem.

It seems important to me that both Californians and people in other States understand how we hope to have this State, standing on its own feet, help its citizens to help themselves to keep serious illness from wrecking homes. Sudden, serious illness is as much a wrecker of homes in other States as it is in California. The threat is national. But there are very strong reasons why this particular social problem can be better solved by States than by the Federal Government. Some assistance to the States from the Federal Government may prove to be needed. But the closer the solution is tailored to each State's needs, the better it is likely to work. Our experience can be of help to other States.

I doubt whether many citizens really know the whole problem of human sickness and health in their own State. California is a fairly typical, progressive State in handling these problems, so, first, let's look at the whole picture there.

In California, as in most other States, we have accepted the broad humanitarian principle that no one will be left to sicken and die for lack of help because they cannot afford treatment. No one questions this principle. Questions arise only about how it should be applied. Many of these questions have been settled by common sense agreement, and are no longer debated in public and legislative forums.

THE STATE HELPS DISEASE VICTIMS

For instance, we have agreed that the State and its subdivisions will help individuals and families that have been hit by tuberculosis if they are not able to help themselves. We tax people who have fortunately escaped this universal scourge to aid its victims. That is the decent, humane thing to do, we all agree.

We take much the same view of mental diseases. They are a human misfortune that springs from the strenuous pattern of our social life. We recognize the humanitarian common sense of mutual cooperation through our State and local government in sharing the burdens of the misfortune of mental illness.

We accept the idea that people who fall sick with any one of dozens of ailments, and have no money to pay for treatment, shall be treated free at city and county and State hospitals and their out-patient clinics. We sometimes call these people the medically indigent, and use the disagreeable word pauper regarding them. The learned and disagreeable words do not change the human facts. These people are our own, and we take care of them, all of us willingly paying taxes to carry a human burden we humanly acknowledge. But we go a step further.

STATE INSURANCE ISN'T NEW

Not many years ago, after a debate that reminds me of the one now going on in California, we accepted the simple principle that a breadwinner who is injured while he labors shall be treated for his injuries and paid during his days of enforced idleness. The cost of this assistance—we call it workmen's compensation—is met by a levy on employers through an insurance system. But the simple fact is that we all help pay for it in the purchase prices of the goods and services we buy. Although workmen's compensation was bitterly fought with all the mustn't-do-this-or-that slogans, it is now taken as a matter of course.

Recently, almost without dissent, we broadened our unemployment insurance law to provide benefits for workers who lose wages because they are sick, not because they are laid off or dismissed. This extension of the unemployment insurance principle to cover wage losses due to illness made simple sense to the people of my State.

THE PLAN BARS STATE MEDICINE, ALLOWS FREE CHOICE OF MEDICAL CARE

The principle that no one shall lack medical care because they can't afford it has a partner principle. It is that people who can afford to pay for their own medical care shall pay for it themselves, without burdening other citizens. So we have two principles: (1) mutual sharing of responsibility for the unfortunate; (2) self-reliance for the fortunate.

These two simple principles are as old as America, and likely much older. To me they are basic ideas about the ways and means by which human beings live together in good fortune and bad luck.

SLOGANS CONFUSE ISSUE

Certainly, they are a lot older than the ideas behind the mustn't-do-this-or-that slogans used to postpone their application. They were accepted as good human principles long before anyone heard of socialism or Fascist regimentation. I confess it disturbs me deeply to hear these ideological blackjack slogans used to frighten forthright citizens out of responding to their American instinct to do something about misfortune when they see it.

What I have said so far is the background to my own thinking about a plan that will keep serious illness from wrecking homes. We have solved the problems of mutual sharing of the costs of sickness and injury on a wide scale and in a variety of ways. Yet there is one important part of the problem we have not solved. We have not found a way to put the principle of mutual sharing to work to help families of such moderate incomes that the costs of serious illness are likely to push them down into a lower social group.

Economic disaster is always close enough to these families, which are the great middle bulk of our society that does most of the hard work. Both the welfare and the outlook of this great middle bulk are profoundly important. Society loses part of its stability when one of these families is compelled to give up its self-reliance. It loses something almost as important when the parents in such a family are forced to abandon reasonable ambitions for their children. I can show you what I mean in a personal way.

WARREN TELLS OWN STORY

I was born and raised in a small California town. My father worked for the railroad, and his pay was never much more than he had to have to pay the family bills for a healthy family. But he and mother squeezed enough out of that pay to send me to college.

I was older before I realized that if my father's health hadn't been perfect during those years, I would have been like most of the other boys in my town. I would never have got to college at all. That means a lot to me, but it isn't the whole story either. My father had his heart set on sending me to college, so I could have a better chance than he had. If his health had failed, I think he might have been a heartsick man, too.

My parents had the good luck to have good health. As Governor of California I have learned a lot about families that had bad luck, and about what the bad luck of serious illness does to ordinary families. Not the well-off or the poor families. They are always taken care of by themselves or society. But the families in between whose self-reliant efforts make the wheels of society go 'round; the families that just naturally want a peaceful, productive community with no nonsense about isms or get-rich-quick schemes.

Let's look at a family I was told about recently. They lived in San Mateo County, which is just south of San Francisco, and had been doing very well. They'd bought a small home, and got a good loan from the bank on it because they had savings of their own to put into it and the husband had a fine record. They have one son and one daughter, and the children were doing excellent work at school.

Then the mother came down with a very serious heart ailment. It was curable, but the kind of thing that means months of hospital care and expensive treatment. By the time she was well enough to care for her family again, they'd lost the home and he had borrowed every cent he could. The strain was too much for the husband and he did what you know a lot of perfectly good human beings do, if you're honest with yourself about it. He drank too much. He lost his job, and along with it a fine chance for promotion that he'd earned by being a good, responsible workman.

I don't know what is going on to that fine family, but my experience with human problems has long since convinced me that four whole lifetimes have been seriously damaged. And that's just one case out of hundreds in California, and out of thousands in America. That kind of tragedy is as familiar as apple pie.

Right now I can hear one of my mustn't-do-this-or-that critics saying: "Yes, but if they had shown the foresight to subscribe to a voluntary health insurance plan they would have been all right."

Of course they would have been all right if they had done any one of several things they did not do, and perhaps could not do. I can see that if every ordinary family always had the foresight and the means to do what hindsight says they should have done, then they wouldn't get into much trouble. The hard fact is they don't have such foresight.

What I cannot comprehend is why some of our best people do not understand the real question society must answer in this problem: How can we help families of moderate income to have the means and the foresight to protect themselves against the tragic consequences of unexpected, serious illness?

The plan I have recommended in California requires that all employees already covered by our unemployment insurance act and all public employees pay 1 percent of their salary or wages up to $3,000 a year into a health service fund. This means that the worker making $200 a month would pay $2 a month. The worker making $250 a month or more would pay $2.50 a month. These contributions would be matched by the employers. Provision is made to include others who may wish to join the system. It is my hope that eventually we can work out methods by which all families of moderate income can participate.

Contributing members of the fund, and their dependents, will be assured payment in full of the costs of hospital and laboratory services, with certain reasonable restrictions, and the costs of medical care in hospital cases. The plan is designed to protect families against the more costly kinds of serious illness, not to provide for sickness involving only home visits by the doctor or office visits by the patient. The very important relationship between doctor and patient in the home and in the physician's own office is not disturbed.

M. D.'S TO WORK AS NOW

Furthermore, my plan does not call for any change in the traditional relationship between the doctor, the patient and the hospital. My belief in the virtue of these traditional relationships is so deep that the plan expressly provides they are not to be changed. Patients are free to choose their own doctor and hospital, just as they do now. Doctors and hospitals are left free to select the patients they want to care for.

There is nothing in the plan to compel employees to use the benefits of the system if they prefer not to. It is carefully provided that the well-to-do can take their benefits in money indemnities to pay their own doctor bills if they wish to do so.

The bill I am sponsoring to put the plan into effect expressly provides that no system shall be created for dispensing medical or hospital care by the State through doctors employed by the State. So, far from regimenting or socializing medicine, the plan expressly prohibits State medicine.

The method for payment of doctors and hospitals is borrowed from the successful experience of private hospitals and medicine. It is the fee-for-service system used by voluntary medical and hospital service plans. I emphasize this because I want it understood that the California proposal is anything but a revolutionary scheme. It represents the minimum change that must be made to make sure people in moderate circumstances will not be bankrupted by serious illness.

The plan supports the highest standards and ethics of the medical profession in a practical way. The California Health Service Authority it establishes is directed to offer needed scholarships for post-graduate medical study when funds are available. I hope that in this way we will be able to improve medical standards in communities where surveys have shown they are too low. There are no hidden strings tied to these scholarships.

One further point. The plan will not disturb existing group voluntary plans, or insurance policies that provide equal or superior protection to the limited number of families that can be covered by them. Voluntary action has made a splendid contribution toward the solution of this problem. I have watched its growth with warm feeling. Yet, as governor of all the people of my State, I have had to say that voluntary action is not enough. Tragic facts made known to me in the day-to-day administration of my office have forced me to the reluctant conclusion that it will never be enough.

I think I have said enough about the plan and its background to convince Look's readers that it is designed to solve the very real problem of payment for the unexpected costs of serious illness, and not to interfere with the methods of professional treatment. Now I would like to say why I think there has been so much opposition to my proposals, and how I feel about this opposition.

I'd like to have you sit down in my chair in the governor's office for a little while so you will get my point of view.

Let's take a fairly typical day. On my appointment list for 11 in the morning is doctor so-and-so. He's an old friend. I am proud to have many old friends in the medical profession. Doctor so-and-so is a sincere man who holds the humanitarian ethics of his profession close to his heart. He is the Good Samaritan if I have ever known one. The respect and admiration of his professional colleagues has made him their spokesman, and he is genuinely troubled as he takes a chair across my desk.

Doctor so-and-so is fearful of what my prepaid medical service plan will lead to for his profession. He has no very specific objection to the bill I have offered to put the plan into effect. I have yielded to every reasonable objection. But the plan, he says, may be the basis on which some later, less responsive Governor will adopt the kind of system of State medicine that proved a destructive failure in Germany and New Zealand. I am, he says, letting the camel of socialization get his head inside the tent of free enterprise. It is socialism, regimentation, compulsion that he fears.

As doctor so-and-so explains his objections to my plan, my hand reaches for a letter that came to me that same morning. I try to explain to doctor so-and-so that his fears are probably not well grounded. But what I say is not convincing to the good doctor. That is understandable. There is really no bone of contention between us. I believe as deeply in free enterprise as he does. There is no flaw in my admiration for his profession, and he knows it.

Finally I fish out the letter I have been thumbing and hand it across the table to him. It's a very ordinary letter, carefully written in pencil on paper from a ruled tablet. The erasures that show on the coarse paper bear witness to the soul-searching that went into writing it. It tells again the same old tragic tale of serious illness and wrecked lives, and pleads with me not to drop my health service plan. Doctor so-and-so reads it carefully, then looks up at me questioningly.

"Which argument would weigh more with you?" I ask. "The argument in that letter or the argument you have given me?"

Take another day. A delegation of insurance men call to impress upon me that my plan is not exactly insurance in the actuarial sense. They bring along an expert to make a learned, mathematical argument. I explain to them as carefully as I can that we can't make a start on the basis of exact insurance principles because no one has had enough experience with exactly this problem. We've got to start the plan with equal percentage contributions to get the experience. If we waited until after we got the experience, we'd never start the plan.

The argument drones on, and again I find myself reaching for a letter. I get them almost every day. They aren't the sort of thing actuaries deal with—they're human stories, not dry figures. This time I read the letter aloud. "Which argument would weigh the most with you gentlemen?" I ask.

WE CANNOT NEGLECT PROBLEM

There it is, as I see it from the Governor's chair in California. Tragic human need versus long-reaching fear of foreign ideologies, and the knife-sharp theories of experts. I do not discount the fears, and the experts are of great service in their special fields.

But I am wholeheartedly convinced that in our struggle to prevent our democratic processes from being infected with foreign ideologies we cannot afford to run away from any of the basic problems of American life.

We must prove to the world that the American system can solve these problems through the application of democratic procedures. But first of all we must prove it to ourselves. To prove it to ourselves we must have faith that our institutions are so practical, so adjustable, and so responsive to every situation that we can make them fully serve our needs, whatever they may be. After that we must have the will to do whatever should be done.

With such determination, we will be willing to face human facts, even unpleasant human facts. We will not hide behind slogans that are easy to repeat, but have no real application to the facts. Such slogans are dangerous to progress.

It is, in my opinion, the misfortune of our times that too many men in public life use slogans to promote or oppose ideas, as if ideas were commodities. Ideas are not commodities. They should not be built up or torn down by slogans, as if they were a new brand of breakfast food. Ideas can be tested only with facts.

SLOGANS DON'T TEST FACTS

My attempts to do something practical about the fact that serious illness wrecks homes have taught me that slogans are the lazy man's way of slaughtering an idea he is unwilling to test against the facts. And that slogans are the designing man's way of defeating an idea he knows he cannot successfully meet on the facts. The experience has increased my determination to solve this problem despite the sloganeers.

I think it is very important that something be done now about the catastrophe of sudden, serious illness in ordinary homes. We have, now, a period of good times and moderate social tensions. We have time to cut and fit and alter and improve a solution to the problem, learning as we go along. We have an opportunity to do this in the States, close to the people who are affected. We can have the advantages of flexibility and intimate contact that the Federal Government can never hope to have.

I do not like to sound alarms about the future. But I would be less than honest about this matter if I did not caution my mustn't-do-this-or-that critics. If times change, we may all be compelled to accept hasty and radical measures that can be avoided if we act now.

COMMENTS ON MARJORIE SHEARON'S TESTIMONY OF MAY 25, 26, 27, 28, AND JUNE 1, 1948. SUBMITTED WITH A LETTER OF JUNE 16, 1948, BY I. S. FALK, DIRECTOR, BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, FEDERAL SECURITY ADMINISTRATION

1. *General Note.*—Mrs. Shearon devoted a large part of her testimony to a repetition of items which have already been considered extensively by this committee (Subcommittee on Health, Senate Committee on Labor and Public Welfare) and by other committees of Congress. Anyone reading her present testimony should have ready reference to these other sources of information. In addition to testimony given by me and by Mr. Wilbur J. Cohen, Assistant Director of the Bureau, in these hearings (see part 4, July 23, 1947, and January 27 and 29, 1948), the reader should know that many of Mrs. Shearon's charges, criticisms, and attacks, and those of Congressman Harness, were considered at length by the Subcommittee on Labor Department and Federal Security Appropriations (Congressman Keefe, chairman), House Committee on Appropriations. The record appears in the hearings of the Subcommittee on the Supplemental Federal Security Agency Appropriation Bill for 1949 (80th Cong., 2d sess., pp. 514–564). That record is particularly significant with respect to Congressman Harness' charges, the report of his Subcommittee on Publicity and Propaganda in the Executive Departments, their alleged findings concerning the missions to New Zealand and to Japan, his letter to Chairman Taber of the House Appropriations Committee, the case of Mr. Jacob Fisher, and various

related matters. It is significant that the House Appropriations Committee dismissed those charges and attacks and made only commendatory comments concerning the work of the Bureau of Research and Statistics in the report which it filed on the appropriation bill H. R. 6355 (H. Rept. 1821, 80th Cong., 2d sess., Apr. 27, 1948, pp. 25–26).

It is even more significant that the Senate Committee on Appropriations subsequently increased the appropriation recommended for the Bureau of Research and Statistics after hearing testimony from Mrs. Shearon in which she made many of the same charges, criticisms, and attacks contained in her present testimony. The interested reader should consult the hearings before the Subcommittee of the Committee on Appropriation on H. R. 6355, United States Senate, Eightieth Congress, second session. Mrs. Shearon's testimony appears on pages 172–192. Replies to her testimony appear in the same volume, as follows: By Mr. J. Donald Kingsley, Assistant Federal Security Administrator, pages 245–266; by Mr. Arthur J. Altmeyer, Commissioner for Social Security, and by me, on pages 266–284. The reader should also consult the report filed for the Senate Committee on Appropriations on H. R. 6355 by Chairman Knowland of the subcommittee (Rept. No. 1444, 80th Cong., 2d sess., June 2, 1948, p. 12).

2. *National Health Assembly.* Concerning Mrs. Shearon's testimony of May 25, 1948 on this subject, see the testimony by Mr. Kingsley (reference in item 1, above).

3. *Costs of health services.* Concerning Mrs. Shearon's testimony of May 26, 1948, in which she alleged I had stated that "the health insurance program would probably cost 10 percent of pay rolls," what I actually said was as follows:

"Before the war, total expenditures for medical service were about $4,000,000,000 a year (exclusive of the cost of medical care for the armed forces). About three-fourths of this total was spent by patients and their families—the direct consumers of medical care. Four to five percent was contributed by industry and philanthropy. The remaining 20 percent was spent by Federal, State, and local governments.

"The prewar level of expenditures for medical services, public and private, may not, however, have been fully adequate to pay the cost of services equal to our modern needs and standards. In the years ahead, especially if our economy operates with stability and at a high level of employment, our total expenditures for health and medical services might advantageously be expanded from the $4,000,000,000 of prewar years to as much as 5, 6, or even nearly 7 billion dollars a year under arrangements that will make adequate services and care available to the entire population. Those larger amounts for the future might be only 6 percent of national income. This should be compared with the 5 percent of national income (a total of about $3,000,000,000) expended about 10 years ago in times of deep economic depression when the degrees of economic freedom and the margins of flexibility in our expenditure patterns were very low indeed. These and all such figures should be measured against the $10,000,000,000 commonly accepted as a conservative estimate of the direct and indirect annual costs of sickness and disability."

[From a paper on Unmet Health Needs, presented before the American Public Health Association, October 4, 1944. *American Journal of Public Health*, 1944, 34, p. 1229.]

Mrs. Shearon says I then went on in that paper to discuss the costs of cash sickness and disability benefits. If the reader will consult the article in question, he will find there was no such discussion there. Our cost estimates for disability insurance (temporary or permanent) do appear in various public documents, but they do not support the incorrect total cited by Mrs. Shearon.

4. *The Friedman testimony on our statistics.*—The reader is invited to consult the comments on that testimony furnished by the Federal Security Agency, appearing in these hearings, part 2, pp. 686–723.

5. *Days of illness under health insurance.*—In her testimony of May 26, 1948, Mrs. Shearon repeats the well-known misinformation about increase in days of illness under health insurance in other countries. Neither Mrs. Shearon nor others whom she has cited as her authority had any statistics that reliably measure days of illness among the insured persons. They had figures on days of incapacity compensated because of wage-loss. Anyone familiar with statistics of this kind knows that in cash sickness insurance the number of compensable days per insured worker increases when the insurance specifications are liberalized, and that unless changes in the benefit specifications are taken into account, the data cannot be used to indicate trends in the real amount of illness or in-

capacity among the insured persons. On this point, the interested reader might consult my discussion on this subject in Security Against Sickness, 1936, pp. 107–117, a volume from which Mrs. Shearon has frequently quoted.

6. *Mr. Jacob Fisher.*—In her testimony of May 27, 1948, Mrs. Shearon revived the charges made by Congressman Harness against Mr. Jacob Fisher, though by this time it was a matter of public record that he had been exonerated of those charges. An investigation of Mr. Fisher's loyalty was made by the FBI. The Board of Inquiry on Employee Loyalty, Federal Security Agency, which had the results of the FBI investigation, reported on March 24, 1948, that the evidence received by it does not warrant the filing of charges of disloyalty against Mr. Fisher, that it had recommended to the Federal Security Administrator that the case be closed, and that the Administrator has approved the recommendation and closed the case.

For a fuller account of this case, the charges made without hearing, and the results, see pp. 532–535 of the House Appropriation Committee hearings cited in item 1 above.

7. *Senate Advisory Council Report and Mr. George W. K. Grange.*—In her testimony of June 1, 1948, Mrs. Shearon confirms her previously expressesd objections against the actuarial work done by Mr. George W. K. Grange, of the Metropolitan Life Insurance Co. in reviewing estimates developed by the Social Security Administrations' Actuary for the 1948 Advisory Council on Social Security, Senate Committee on Finance. Mrs. Shearon said (transcript, p. 1053): "I have since learned that he (Mr. Grange) was formerly with the Social Security Board also, so the tie-in there, as I said, was very, very strong. * * *."

According to the official records, Mr. Grange was employed by the Social Security Board as a temporary actuarial mathematician for 3 days in 1937 and for 8 days in 1938.

8. *Capitation payments and per capita costs.*—In her testimony of June 1, 1948, Mrs. Shearon repeats her argument that I advocated the capitation method of paying doctors under health insurance. She buttresses her argument first by excerpting from their context part of one sentence from one paragraph and all of one sentence from another paragraph in an article of mine published in the New England Journal of Medicine (230, 1944, pp. 243–249). The reader will be able to see how she misrepresented my views by reading the whole of the two paragraphs from which those sentences (italics here) were taken:

"*There is little doubt that some of the most serious deficiencies of present-day medical practice result from the fee-for-service method of payment,* because it discourages early, preventive, or adequate care—especially among people of modest means—at the same time that it puts a premium on excessive treatment in some cases and inadequate treatment in others, and on various types of fee-splitting practices. Some of these objectionable features would be carried over into the insurance system, despite precautions that might be taken. Although the patient would no longer be barred from needed services, there would be a risk that some physicians would load unwarranted service charges on the insurance fund. Since the aggregate amounts available for all payments to physicians would be limited, the result might be a competition for patients and for volume of services almost as inimical to professional standards as that which occurs today. Through the downward prorating of physicians' bills if they are excessive, the insurance fund can be protected against extreme unwarranted costs. For the rest, the problem would be largely a matter of intraprofessional controls.

"*Practitioners here, like those in Great Britain, would probably turn to a capitation or a salary basis of payment, because they would learn by experience that these methods are more satisfactory for them as well as for their patients.* Nevertheless, I do not agree that the insurance system should bar the fee-for-service method. So long as a majority of physicians prefer or insist on a fee basis, it should be accepted by the social-insurance system. At the same time, it should give full opportunity for the development of organized group practice where this arrangement is preferred by physicians and insured persons. In other words, the insurance system should build on what now exists, and at the same time should build toward better arrangements by leaving latitude for change and improvement as rapidly as change is desired by or is acceptable to those who are most concerned."

Then Mrs. Shearon cites, as further evidence that I advocated the capitation method of payment, the fact that I repeatedly used per-capita costs in the volume on medical care insurance which we furnished the Senate Committee on Education and Labor and which they printed as their Committee Print No. 5, July 8, 1946. This citation by Mrs. Shearon evidences utter confusion or misrepresentation. Anyone who consults that volume will find that the term "per-capita costs," and dollars expressed as per-capita costs, merely give the costs dividend by population, and that such per-capita costs have no bearing upon, or relation to, the method of paying for services.

9. "*Ultimate objectives.*"—In her testimony of June 1, 1948, Mrs. Shearon alleges that we "have in mind as an ultimate objective * * * a complete national medical service, a salaried service, such as they have in Russia" (Transcript, p. 1124). In support of this she quotes excerpts from the Provisional Record of the Social Security Consultation on Income Maintenance and Medical Care, called by the ILO in Montreal, July 9–12, 1943.

Her discussion of this subject is confused and her quoted excerpts are misrepresentations. The plain facts are that the conference was discussing, and suggesting revisions in, a draft document which had been prepared by the ILO staff to indicate elements which should be weighed by any country when considering one method or another for dealing with its medical-care problem. Mrs. Shearon quoted from the Provisional Record only the introductory lines of paragraph 403 in the revised ILO document. The true meaning of those lines, and Mrs. Shearon's misuse of them, are evident when they are seen in their original setting. Following is the complete text of paragraph 403 from which she excerpted, and also the complete text of the companion paragraph (par. 405) which immediately followed and from which she did not quote (italics in the original):

"403. Indications for medical care through public services. *Such services may be preferred, especially as an ultimate objective, in the light of experience accumulated under contributory social insurance:*

(a) *because all prospective beneficiaries have same title to benefits;*

(b) *because provision for essential need should not depend on any qualifying conditions;*

(c) *when it is desirable to integrate medical care services with other health services.*

"405. Indications for medical care through social insurance services. *Such services may be preferred:*

(a) *where services are limited to a section of the population or to a specified area;*

(b) *when wholly or principally financed by contributions, with or without partial financing from general tax funds;*

(c) *where the contributory mechanism already exists for other classes of social insurance.*"

From this, and similar ILO material, Mrs. Shearon concocts an international plot and program. For further analysis on this subject, see these hearings, part 4, pp. 1729–39, and 1780–86, for my notes on her "Blueprint" and on the anonymous article which Mrs. Shearon said had been prepared by Miss Hazel Huffman and which was published in *Medical Economics*, November 1945.

10. *United States Membership in ILO.*—Concerning Mrs. Shearon's garbled account of this subject in her testimony of June 1, 1948, see my notes on this subject in commenting on her "blueprint" (in these hearings, pt. 4, pp. 1729–39).

11. *Authority to study health insurance.*—In her testimony of June 1, 1948, Mrs. Shearon gives her account of the history of section 702 of the Social Security Act, and alleges Congress did not want the Social Security Board to study health insurance. All of this is her own invention. For the facts in the case, see Mr. Altmeyer's testimony before the Senate Appropriations Committee, cited in item 1, above.

12. *Mrs. Shearon's views in 1939.*—Concerning Mrs. Shearon's views at the time Senator Wagner's 1939 health bill was being developed (her testimony of June 1, 1948), see documents prepared by her and introduced in these hearings by Senator Pepper (pt. 4, pp. 1800–1820). It will be plain that at that time she was intemperately critical of the proposals being considered because they did not go far enough in covering population groups through compulsory health insurance and because they exposed otherwise self-supporting people to a "means" test in order to obtain medical care.

13. *History of the Wagner-Murray-Dingell bill.*—For comments on Mrs. Shearon's testimony on this subject, see my testimony of July 23, 1947 and January 27, 1948 (these hearings, pt. 4), and my notes on her Blueprint, pp. 1729–39.

14. *Article in Administrative Medicine.*—Mrs. Shearon's account (her testimony of June 1, 1948) of the writing of an article for this volume and the handling of an honorarium for it is basically false, since I never asked her or any other

member of our staff to work on Government time for outside pay. It is significant that she did not make these charges about receiving outside pay for work on Government time to the competent administrative officers of the Social Security Board at the time, and that she comes up with them only now—nearly 10 years after the alleged event.

The record shows that in January 1942, directly after the volume containing the article was published, I wrote to the publisher as follows (italics added here):

"May I suggest a particular method of handling the honorarium which was originally offered for the article? When the job of preparing it was first undertaken, Mrs. Marjorie Shearon undertook to collaborate with me and it was our agreement that she was to receive one-half of the honorarium mentioned in the first letter from Dr. Emerson. Later, when she left the staff of this Bureau, and could not participate in the further revision of the document, she asked to withdraw from the project and requested that her name be dropped from the joint authorship which the manuscript carried. Inasmuch as she did all of the work which her original commitment required of her when the invitation from Dr. Emerson was accepted, I believe she is entitled to receive so much of the honorarium as was first intended for her, *particularly because it is my recollection that she did her work on this job out of office hours and in her leisure time.* I would, therefore, suggest that a check in the amount of one-half of the honorarium be sent directly to her at the following address: P. O. Box 4034, Chevy Chase, Md."

HEALTH INSURANCE PLAN OF GREATER NEW YORK,
New York, N. Y., June 3, 1948.

HON. JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: In connection with the studies your committee has been conducting on health services, it occurred to me that you might wish to have for the record before it is closed a brief account of some of the problems faced by the HIP in its development. Although we feel that we have made substantial progress and are well on the way toward achieving a demonstration of the fact that comprehensive medical care of high quality can be provided for families of modest and low income through a voluntary prepayment plan, we face obstacles from time to time which might be of interest to you and which I thought you might wish to put in the record of your committee's studies before they are closed.

The enclosed clippings from the New York Times and the New York Herald Tribune relate the recent action of the New York State Medical Society which we very much regret. Also enclosed is a statement made by Dr. Rappleye in regard to this action and copies of editorials which appeared in these newspapers and in the Watertown Daily Times with respect to the State society's action.

The question will naturally arise in your mind as to why the New York State society does not approve the HIP. The principal difficulty lies in the fact that under the standards of the State society for the approval of voluntary insurance plans, the governing body of the plan must contain a majority of physicians and these physicians must be recommended by the State medical society. A copy of the State society's standards for approval is attached. The organizers of HIP feel that the organization is a community enterprise which is in effect a banding together of families of modest and low income for the purpose of purchasing comprehensive medical care of high quality. As such, the plan should, in the view of HIP's incorporators, be under the control of community representatives including a strong representation but not a majority of physicians. So long as the HIP adheres to this principle which it feels to be exceedingly important, it cannot be approved by the New York State Medical Society unless, of course, the society should change its rules for approval. The HIP is proud of being a community organization and feels that organized medicine is mistaken in its view that voluntary insurance plans should be exclusively under the control of the profession.

It should be recognized that the lack of State society approval in no way reflects upon the standards of quality of the medical services offered by HIP. Indeed, the society's rules for approval make no mention whatever of medical standards. HIP's professional standards are guaranteed, in the first place, by the outstanding physicians who serve on its board of directors, a list of whom is attached. Whereas HIP regards the general policy of its program and organization as properly a matter of community interest, it feels equally strongly that physicians should have unquestioned control over all professional matters. For this reason, HIP has appointed a medical control board composed entirely of physicians and including representatives of county medical societies, the New York Academy of Medicine, the physicians of the HIP board of directors and of the participating medical groups, which establishes and supervises the maintenance of professional standards and in general is in control of all professional aspects of the program. In this connection it should be noted that organized medicine in New York City was offered majority representation on HIP's medical control board. In spite of the fact that written agreements with HIP were made by all the county medical societies to provide such majority representation on its medical control board, and in spite of repeated assertions by organized medicine that its primary concern in an insurance plan is to guarantee to the public that high medical standards are maintained, the medical societies here have for over a year failed to take advantage of the opportunity offered by HIP to assume control of the professional aspects of its program.[1]

I should add that HIP's bylaws provide that its medical control board may be overruled by the board of directors in a professional matter only with the concurrence of a majority of the physicians of the board of directors. Thus, in respect to medical matters, final control of the health insurance plan rests entirely with physicians.

We believe that this division of function is a proper one and that in the public interest a program in which the health of the subscribers is at stake, and which is supported from the premiums paid by subscribers and their employers, should be controlled by community representatives.

This issue of the type of controlling organization best suited for a voluntary medical insurance plan has arisen in many parts of the country and has frequently resulted in difficulties for various groups such as employers, trade-unions, cooperatives, fraternal organizations, etc., which have sought to develop prepayment plans for their employees or members. Recently there have been indications that this problem and several others may be jointly discussed by the representatives of the medical profession and of groups such as I have mentioned, in an effort to reach a better understanding and possible agreement. If this can be accomplished it will be an important step forward in the development of satisfactory voluntary medical insurance plans. If these plans are to grow in size and in scope of service to a point where they can be of maximum usefulness to the public, it seems to us that experimentation with different methods should be encouraged rather than obstructed, and that only through such experimentation can we hope to reach sound conclusions as to the methods best adapted to promote satisfaction for both the professions and the public.

Senator H. Alexander Smith, or New Jersey, has also expressed an interest in HIP problems, and I am sending him the same material.

Sincerely yours,

Dean A. Clark, M. D., *Medical Director.*

[From the New York Herald Tribune of May 20, 1948]

Doctors Urged by Society to Boycott H. I. P.—State Medical Group Says They Should Join Only in Six Plans It Approves

The Medical Society of the State of New York advised its 22,000 members yesterday to participate only in the six voluntary health insurance plans which are operated with its approval.

Doctors were thus advised not to participate in the Health Insurance Plan of Greater New York and others operated by insurance companies, by industrial firms for the employees, and by labor unions and fraternal orders for their members.

The society's stand was expressed in a resolution passed by its house of delegates, or legislative body, meeting at the Hotel Pennsylvania. The resolution, introduced by Dr. Thomas D'Angelo, of Queens, advises its members "not to become participating physicians in any voluntary health insurance plan unless it has been approved by the Medical Society of the State of New York."

---

[1] The medical societies of New York, Kings, and Richmond Counties and the New York Academy of Medicine have sent representatives to the medical control board. The medical societies of Bronx and Queens Counties and the coordinating council of the five county medical societies have not sent such representatives. The number of representatives of organized medicine now on the medical control board, therefore, is less than half of the total number of 11.

CONFLICT IN PHILOSOPHIES

Only the six so-called doctors' plans, which subdivide the State into six regions with headquarters in New York City, Albany, Utica, Syracuse, Buffalo, and Rochester, have been approved by the society.

The sweeping resolution stems from a conflict between differing philosophies on health insurance. The Medical Society approves the doctors' plans, which stress the relationship between the patient and his family doctor, who would recommend an appropriate specialist in case of serious illness. The emphasis is on cures for illnesses which have already set in.

The H. I. P. is based on care by groups of doctors which contain general practitioners and the various specialists to whom subscribers can go for any sort of treatment. Subscribers may choose or are assigned to a particular group under the plan. A single weekly fee, graduated according to the size of the family, pays for any contingency, and the preventive nature of the plan is expressed in its emphasis on diagnostic work, annual physical examination, and health education programs.

BOTH PLANS SUCCESSFUL

Both types of plans, just over a year old, have reported considerable success. The doctors' plan has 1,200,000 members and the H. I. P. 120,000. The latter was chosen by the city of New York for its employees and is based on equal payments by employer and employee. The doctors' plans can be carried on a 50–50 basis or wholly by the subscriber.

The six approved plans are the United Medical Service, of New York; the Northeastern New York Medical Service, Albany; the Central New York Medical Plan, Syracuse; Medical and Surgical Care, Utica; Genessee Valley Medical Care, Rochester; and the Western New York Medical Plan, Buffalo. Since the resolution applies to medical-care plans, it is not applicable to the Blue Cross plan providing insurance for hospital expenses.

Election of Dr. John J. Masterson, Brooklyn radiologist, as president-elect of the society, was announced at its annual dinner last night at the Pennsylvania. Dr. Masterson will become president in 1949, succeeding Dr. Leo F. Simpson, of Rochester, who was installed as president for 1948 at the dinner. He succeeded Dr. Louis F. Bauer, of Hempstead, Long Island.

[From the New York Times of May 20, 1948]

STATE DOCTORS GET WARNING ON "PLANS"—MEDICAL SOCIETY "ADVISES" THEM AGAINST PARTICIPATING IN ANY IT HAS NOT APPROVED—ONLY SIX ENDORSED SO FAR—BLOW SEEN TO CITY-SPONSORED PROJECT—HOSPITALS "PRACTICING MEDICINE" ARE ASSAILED

(By William L. Laurence)

The house of delegates of the Medical Society of the State of New York adopted a resolution at its one hundred and forty-second annual meeting yesterday at the Pennsylvania Hotel recommending that the society "advise" its more than 22,000 members "not to become participating physicians in any voluntary health insurance plan unless it has been approved by the Medical Society of the State of New York."

At present only six voluntary nonprofit medical care plans in New York State have been approved by the Medical Society of the State of New York. These are the United Medical Service in this city; Northeastern New York Medical Service, Albany; Medical and Surgical Care, Utica; Central New York Medical Plan, Syracuse; Genessee Valley Medical Care, Rochester; and Western New York Medical Plan, Buffalo.

These plans operate under the sponsorship and control of the medical profession. Their total membership by the end of 1947 was 1,023,615 with more than 17,000 physicians participating.

CITY-BACKED PLAN NOT APPROVED

Not yet approved by the State medical society is the Health Insurance Plan of Greater New York, initiated under the sponsorship of the late Mayor F. H. LaGuardia and heartily endorsed by Mayor O'Dwyer after a careful investigation as the most suitable health insurance for employees of New York City.

The resolution therefore was interpreted as an attempt to discourage New York physicians from participating in the plan, since such participation would be going contrary to the official policy of the society.

While the society only "advises" its members, it was pointed out that advice in such cases may go a long way, as few physicians, particularly the younger ones anxious for advancement and desirable hospital appointments, would wish to offend the powers that be in organized medicine.

Wide acceptance of the advice would seriously affect not only the Health Insurance Plan of Greater New York, or H. I. P., as it is know, but many other voluntary health insurance plans, some of which have been in existence for more than 50 years.

In addition to health insurance protection offered by many insurance companies, there are plans being operated by industry and by labor unions. Among these are the Amalgamated Clothing Workers of America, the Consolidated Edison Co., and the Endicott-Johnson Co.

PRACTICING BY HOSPITALS SCORED

The house of delegates, official-policy-making body of the society, also adopted a resolution asking the society's council "to use its efforts to prevent hospitals from practicing medicine and interfering with the private practice of medicine, and to use all moral and, if necessary, legal methods for this purpose."

The house also adopted a report by the planning committee for medical policies, one section of which "views with alarm the formation of group clinics controlled by hospitals and medical schools." The report added that the committee "vigorously protested and opposed such activities."

The house also adopted a resolution urging Congress to vote for United States participation in the United Nations World Health Organization. In other actions, the delegates urged that the State health department study the problem of the prevention and alleviation of alcoholism, and also empowered the society's president to appoint a committee for national defense and disaster preparedness.

The house also voted to create a memorial fund for the education of children of members of the society who were killed or died in service in World War II.

Dr. John J. Masterson of Brooklyn was chosen president-elect of the society, Dr. Leo F. Simpson of Rochester assumed office as president at the annual dinner last night.

First prize for scientific exhibits was awarded to Dr. Gilbert Dalldorf, department of health, Albany, for his exhibit on vaccination against tuberculosis with BCG vaccine. Second prize went to Dr. Lee A. Hadley of Syracuse. First prize in the clinical awards went to Dr. William Benham Snow, Columbia Presbyterian Medical Center, for his exhibit outlining a program of physical medicine. Second prize in this group went to Drs. David J. Graubard, Milton H. Waldman, and Raphael W. Robertazzi of Reconstruction Hospital and the Post-Graduate Medical School and Hospital, for their exhibit on intravenous procaine.

[Editorial from Watertown Daily Times, Tuesday, May 25, 1948]

Doctors and Progress

Action of the house of delegates of the New York State Medical Society in objecting to the Red Cross reestablishing its wartime blood-donor program has caused concern among doctors in other places besides Watertown. The house of delegates would provide free blood for indigents only.

If the house of delegates has taken this action on the assumption that the amount of free blood will not equal the demand, especially in the large cities, this can be determined after adequate test. It has been the local experience that to depend upon friends and relatives of patients to replenish blood banks has not always been satisfactory. The Red Cross system worked better.

It is not only the action of the house of delegates with respect to free blood that has caused concern, however. That governing body of the State medical society also warned doctors against participating in the health insurance plan of greater New York. This plan has been operated under the highest medical standards and is directed by eminent medical men. It is entirely on a voluntary basis.

One would think that plans of this kind would be welcomed by medical societies as the most effective means to overcome the growing sentiment for what the doctors call socialized medicine. Instead, however, the house of delegates takes what the New York Herald Tribune calls a step backward.

The more medical societies put obstacles in the way of worthy and reputable voluntary health-insurance plans, the greater the demand will be for national compulsory health insurance which most of us would like to avoid if at all possible.

In this county the Jefferson County Medical Society has gone on record in favor of the Red Cross reestablishing its blood-donor service. Tonight a meeting will be held between representatives of the society and the Red Cross in an effort to work out a concrete plan.

STATEMENT BY DR. WILLARD C. RAPPLEYE, CHAIRMAN, BOARD OF DIRECTORS, HEALTH INSURANCE PLAN OF GREATER NEW YORK

It is regrettable indeed that the New York Medical Society should record opposition to the efforts of physicians, hospitals, industry, the city of New York, national organizations, and other groups to establish and provide adequate modern medical care for the community. The action of the State society is against the public interest.

It is evident that the society has disregarded the advice it was given by Mr. Bernard Baruch a few months ago when he said "too many doctors have been fighting a rear-guard action for too long."

The Health Insurance Plan of Greater New York, one of the numerous plans the society has advised its members not to join, by offering an opportunity to persons of moderate means to prepay for comprehensive medical service through group practice, is making it possible for the people of New York to get high standard medical care as a preventive measure and as complete treatment for their illnesses and injuries. Since employers pay half the costs in this plan, it is possible for a great many people to join who otherwise would have to rely on public, private, and professional charity for their medical care. Ours is the self-respecting way to pay for medical service; this is the method for reducing the taxpayers' burden.

This action by the society disregards, too, the conclusions reached by the planning committee of the medical care section of the recent National Health Assembly in which national representatives of the public and the professions took part. These conclusions were that "voluntary prepayment group health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care. * * * Hence such plans should be encouraged by every means."

HIP is designed to provide comprehensive medical care on a prepayment basis for this community and will continue to expand its program. We are confident that the people of New York will continue to support this plan and the doctors who are participating in it.

DEPARTMENT OF MEDICAL CARE INSURANCE

(Conducted by George P. Farrell, Director, Standards for Approval of Medical Society of the State of New York of Voluntary Nonprofit Medical Care Plans in New York State)

(Excerpt from the New York State Journal of Medicine, July 15, 1947)

Local approval

1. Approval of the County Medical Society in whose area a plan operates.
2. In the event a county society does not approve a plan, a special committee of three members be appointed; one by the plan, one by the county medical society, and one by the Medical Society of the State of New York, to investigate and study the reasons for withholding approval.
3. If, in the opinion of a majority of the committee, after consideration, approval will be granted to the plan.

Professional control

1. The governing body must contain a majority of physicians.
2. These representatives shall be members of and recommended by the Medical Society of the State of New York.
3. The medical profession is to assume responsibility for the medical services included in the benefits.

Free choice of physician

1. There shall be no regulation which restricts the choice of a qualified doctor of medicine in the locality covered by the plan, who is willing to participate and render service under the conditions established.
2. The method of rendering service must retain the personal, confidential relationship between the patient and physician.

Subscriber benefits

Subscriber benefits may be terms of cash and/or service units.

Claims payments

1. When care has been rendered by a participating physician and claim filed for such care, payment shall be made direct to the participating physician. When subscriber has paid the physician, then payment may be made to subscriber upon presentation of a receipted bill. This method of payment should be discouraged and should apply only in instances where subscriber has paid the physician.
2. When care has been rendered by a nonparticipating physician and claim filed for such care, payment shall be made direct to the nonparticipating physician or to the subscriber upon presentation of receipted bill.

Underwriting

1. Subscriber premium rates should be adequate to provide for the benefits offered and the risks involved in the contract.
2. Plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber.
3. All plans shall conform with State statutes as set up under the New York State Insurance Department with due consideration for earned premiums, administrative costs, and reserves for contingencies.

Enrollment

Enrollment procedures shall be on a sound basis so as not to expose the plan to adverse selection.

It is recommended that enrollment be offered to individuals at the earliest possible date that experience of the plan warrants.

Promotion

Descriptive folders and all promotional material shall state clearly and accurately the benefits offered by a plan, and also in the same manner, exclusions in the contract.

Reports

All plans which have received approval, or are seeking the approval of the Medical Society of the State of New York, shall submit quarterly reports on forms provided for that purpose to the Bureau of Medical Care Insurance of the Medical Society of the State of New York.

Duration of approval

Approval by Medical Society of the State of New York shall be for a period of 1 year, at the end of which, review of all plans will be made by an appropriate committee of the Medical Society of the State of New York, to determine eligibility for renewal.

Comment

The subcommittee on medical-expense insurance of the council committee on medical economics of the Medical Society of the State of New York has felt for some time that New York State voluntary nonprofit medical-care plans should conform, in their general operation and set-up, to certain requirements, in order to be eligible for approval by the Medical Society of the State of New York. The above standards were drafted by the committee approved by the council and adopted by the house of delegates of the Medical Society of the State of New York at its annual session in May 1947. They conform in general to the outline of requirements of the council on medical service of the American Medical Association for approval of such plans by that body, with other necessary additions that were deemed advisable.

The purpose of the standards is to maintain medical control, preserve the established doctor-patient relationship, and aid in accurate promotional material. The filing of quarterly reports by each plan on membership, claims, financial status, etc., with the bureau of medical-care insurance of the State society will permit compilation of statistical statements and aid in the establishment of benefits and premiums under sound underwriting principles.

The six plans operating in New York State are approved by the Medical Society of the State of New York and subsequent approval will be granted annually, following a study and review of each plan's adherence to the standards, by an appropriate committee of the State society.

It is the feeling of the medical-care-insurance bureau that these standards will maintain and further promote the voluntary nonprofit medical-care movement and assure continued benefits to the public and the doctors.

[From the New York Herald Tribune, Saturday, May 22, 1948]

A STEP BACKWARD

We had hoped that the reactionary influences which have too long prevailed in this country's powerful medical organization were going down to defeat. Leaders in the profession have aided and encouraged such hopeful developments as voluntary prepayment plans and group medical practice, declaring them to be essential to secure better distribution of medical care.

Action by the Medical Society of the State of New York designed to retard promising efforts along those lines is therefore the more disheartening, the harder to credit. The society is now advising its members against participation in any voluntary health insurance plans except those it specifically approves. It thus warns doctors against service in the health insurance plan of Greater New York, to which its approval is not accorded. This plan is operating under the very highest standards of medical care, and is directed by as reputable, and indeed as eminent, medical men as the city has. It offers preventive and comprehensive care to families of moderate incomes. It has not the society's approval because of essentially technical differences, one of which concerns the "proper" doctor-patient relationship. But since the plan is entirely on a voluntary basis, differences between it and those directly sponsored by the medical society should be welcomed for their potential contribution to better practice.

The society's decision was no doubt influenced by doctors' opposition to socialized medicine—opposition with which we sympathize. We do not sympathize when fear of socialized medicine turns into a bugaboo that routs reason. The certain way to increase demand for national compulsory health insurance is to put barriers in the way of worthy and wholly reputable voluntary plans. The barrier the society now raises is formidable. Doctors are extremely sensitive to the advice of their organized societies because professional advancement may depend upon good standing therein.

We trust that doctors who subscribe to the kind of progress represented by H. I. P. will not be constrained by this probably transient bit of medical society advice. For to the public which they serve it makes no sense whatever.

[From the New York Times, Friday, May 21, 1948]

A SOUND HEALTH PLAN

The house of delegates of the Medical Society of the State of New York has adopted a resolution recommending that the society advise its more than 22,000 members "not to become participating physicians in any voluntary health insurance plan unless it has been approved" by the society. According to our news report, this resolution is interpreted as an attempt to discourage New York physicians from participating in the health insurance plan of Greater New York.

Probably no system of voluntary health insurance ever developed for this city has been the subject of more careful medical and actuarial consideration than the health insurance plan of Greater New York. The local county medical societies were consulted before the plan was put into effect to make certain that there was no violation of medicine's ethical code. The late Mayor La Guardia sponsored the plan as one that city employees should support. Mayor O'Dwyer has been equally strong in his endorsement. Three out of five local medical societies and the New York Academy of Medicine agreed to cooperate in experimenting with the plan by appointing physicians to sit on the control board. If the many physicians who are now rendering good medical service under the plan at a cost that thousands in the employ of business firms and the city can easily meet were to follow the society's advice and withdraw, the cause of self-help in health insurance would receive a heavy blow.

The State Medical Society has a proper professional right to scrutinize any health insurance proposal and to decide whether or not it meets accepted medical standards of quality. It should not imply that the physician who participates in a sound and ethical health insurance plan which may not have come before it courts professional ostracism.

(Subsequently communications, statements, and exhibits were forwarded to the chairman as follows:)

THE BROOKINGS INSTITUTION,
Washington 6, D. C., July 16, 1948.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Senate Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

MY DEAR SENATOR SMITH: Your office has sent us a copy of the review, prepared by Michael M. Davis and Dewey Anderson, relating to the Brookings' report on medical care for the individual, which was later formally entitled, "The Issue of Compulsory Health Insurance." We have read this review and see no reason for submitting to your committee anything in the nature of a formal reply to it. Intelligent readers who examine the two documents with care can reach their own conclusions regarding the soundness of our report and the criticisms of it made by two of the leading proponents of compulsory health insurance.

Very sincerely yours,

HAROLD G. MOULTON, *President.*

NATIONAL PHYSICIANS COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE,
Chicago 1, Ill., August 18, 1948.

Senator H. ALEXANDER SMITH,
Chairman, Subcommittee on Health of
Senate Committee on Labor and Public Welfare,
Washington 25, D. C.

DEAR SENATOR SMITH: There has been placed in our hands by Mr. P. R. Rodgers, committee clerk, galley proofs of text of a letter addressed to you over the signature of the Honorable James E. Murray, Montana, and comments and materials submitted by Senator Murray for inclusion in the record of the hearings on S. 545 and S. 1320. These galley proofs were accompanied by a letter in which Mr. Rodgers states:

"This material is being sent to you for your information. Please be advised that if you care to submit a statement in reply to his comments and materials, the subcommittee will be pleased to include it in the record of the hearings."

Senator Murray's letter and the "comments and materials" are replete with glaring misstatements, half-truths, innuendos, and veiled threats which, if read by the uninformed, would naturally lead to wrong and possibly dangerous conclusions. Therefore, we are pleased to take advantage of the invitation to submit a statement in reply to this letter and the "comments and materials."

Hence, we are placing in Mr. Rodgers' hands a statement with substantiating documentary evidence, which, with a copy of this letter, we request be made a part of the final published record of the Subcommittee on Health, relating to activities of the National Physicians Committee and the public hearings on S. 545 and S. 1320.

Sincerely,

JOHN M. PRATT, *Administrator.*

STATEMENT OF THE NATIONAL PHYSICIANS COMMITTEE IN ANSWER TO CHARGES INSERTED IN THE RECORD OF THE SUBCOMMITTEE ON HEALTH BY HON. JAMES E. MURRAY, SENATOR FROM MONTANA

This statement concerns the activities of the National Physicians Committee in connection with opposition to legislation that has been introduced in the Congress, which would provide for compulsory health insurance and the political distribution of medical care in the United States.

The Congressional Record of Tuesday, August 3, 1948, reproduces a statement of Hon. James Preston Kem, Senator from Missouri, as follows:

"There are two ways of life competing for supremacy in the world today. One is the Russian system based on the Marxian principles of the abolition of private enterprise as the means of production.

"The other—the American system—is based on the principle of free enterprise and personal initiative."

There is unanimous agreement on the fact that our American institutions cannot survive under the forms and principles of socialism as in England or communism as in Russia.

Compulsory health insurance is socialized medicine. Editorially, the National Physicians Committee has said:

"There are in this country sincere, responsible, truly patriotic American citizens who, with unimpeachable motives, lend their positions and their substance to the promotion of compulsory sickness insurance. They do not comprehend. Actually it is merely a device for centralizing and consolidating political control. It is an instrument of world revolution leading to Communist conquest."

These conclusions are based on findings of an official agency of the United States Congress—the Committee on Expenditures in the Executive Departments—which reads in part:

"Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."

The origin and the sequence of compulsory health insurance progression is fully covered in an editorial, Socialized Medicine and Communist Purpose, a copy of which is attached as exhibit No. 1 accompanying this statement.

Senator Murray's statement and "comment and material" provide a perfect example of attempts to discredit by insinuation and half-truths. These fulminations are packed with invective, innuendo, and threats. They illustrate perfectly an intellectual dishonesty and deliberate misrepresentation that is characteristic of the efforts to force compulsory health insurance on the American people. For instance, note the following phrases culled from Senator Murray's letter and "comment and material":

> "Pressure of the most pernicious sort."
>
> "Vast quantities of false, misleading, and vicious propaganda."
>
> "The second was a despicable set of lies addressed to the editors of the country."
>
> "In the past, this organization has been repeatedly guilty of using the vicious Hitler tactics of the 'great lie'."
>
> "This depraved group, in their names, has reached a new low."
>
> "Not content with this snide attack, they are labeling the proposal out and out communistic."
>
> "To condemn this cheap mendacious appeal to emotionalism and insults to the intelligence of the American people."
>
> "That they permit this vicious so-called National Physicians Committee to continue its activities."

To any intelligent reader, these extremes in expression substituted for logic and argument alone are sufficient to brand as doubtful and dangerous the cause they seek to promote.

Continuously, over a period of nearly 10 years, the National Physicians Committee has devoted all of its resources, energies, and efforts to preserving in this Nation the American way of life, the profit motive, and freedom of enterprise system in full knowledge that our institutions cannot withstand the establishment of a compulsory health insurance. The National Physicians Committee will welcome investigations leading to determination of whether or not advocacy of the maintenance of the American way of life and the preservation of American concepts is either illegal or considered to be subversive.

Senator Murray states: "The national committee spent over $100,000 during the first 3 months of 1948 alone. It has spent it to bring constantly increasing pressure of the most pernicious sort to bear on Members of Congress—partly through the distribution of vast quantities of false, misleading, and vicious propaganda, obviously designed to influence the forthcoming election."

Comment: The National Physicians Committee never has published, released, or distributed any material designed to elect or defeat a candidate for any Federal or any other political office. This can be stated without equivocation or qualification. Individual physicians and local physician groups have opposed candidates who advocate compulsory health insurance. They have expressed approval of and supported candidates who opposed the socialization of medicine and the socialization of our institutions in the United States.

Senator Murray states: "It calls itself 'a physicians' committee,' yet is required by law to list all contributions of $500 or more. Its 1947 registration does not list a single physician."

Comment: Obviously Senator Murray secured this information from the official NPC report on file with the Clerk of the House of Representatives. This report indicated total revenues for 1947 of $389,927.88, of which only $72,000 was from drug manufacturers, leaving $317,927.88 from other sources. More than $300,000 of this amount was contributed by physicians and dentists in sums ranging from $5 to a maximum of $250 each. Senator Murray had and has full knowledge of the fact that amounts under $500 are not to be listed individually in the reports to the Clerk of the House of Representatives. Knowing this, he deliberately attempts to create the impression that the major source of income of the institution is from industrial concerns, that it does not have the approval or support of physicians and dentists and has no right to the name "National Physicians Committee." The endorsement and approval of the professions is evidenced by the fact that more than 80 percent of total revenue for 1947 came from contributions by individual physicians and dentists.

Senator Murray states: "For the first 3 months of this year, lists $53,500 as revenue received from 'patent medicine manufacturers.'"

Comment: The term "patent medicine manufacturers" is employed in derision—as a damning epithet intended to smear representatives of ethical concerns. Actually N. P. C. supporters are not patent-medicine manufacturers. They are the legitimate industries that provided the research and the drug products which were a mainstay for this country and its allies before, during, and after the World War. Senator Murray ignores $106,388.90 received during the same period in the form of individual contributions from physicians and dentists and made public in the report from which his figures were secured. Obviously, this is a deliberate attempt to deceive and mislead the members of the Subcommittee on Health, Members of the Congress, and the public through the use of only a part of the available information.

Senator Murray states: "The committee is supposedly created for extending medical service to all people but, although it has spent hundreds of thousands of dollars in propaganda against measures aimed at such extension, there is no record of its having spent a nickel in such a way as to extend medical care to anyone."

Comment: The National Physicians Committee takes full credit for lines of research and educational effort which led to:

(*a*) An understanding of the nature and scope of the health care distribution problem in the United States.

(*b*) The acceptance of the principle of physician sponsored prepayment medical care plans by the profession.

(*c*) The general acceptance of the need for and the value of group insurance programs for employees of business institutions and industrial concerns.

These efforts resulted in two remarkable documents entitled respectively: (1) "The American People" and (2) "Opportunity for Private Enterprise."

These deal with no other matter than that of providing medical care for all of the people. Expenditures on these and similar efforts have totaled hundreds of thousands of dollars.

Senator Murray states: "It calls itself nonpolitical, yet is registered as a lobbying organization, and its representatives infest the halls of Congress."

Comment: This statement is intended to cast doubt on the integrity and legitimacy of operation of the National Physicians Committee. The National Physicians Committee is registered under Public Law 601, and makes full disclosure of all receipts and expenditures in quarterly statements submitted to the Clerk of the House of Representatives. It has never stooped to lobbying in the commonly accepted meaning of the term. However, it complies not only with the letter, but the intent and spirit of Federal statute and proudly, with all of the vigor and resources at its command, opposes the enactment of a compulsory health-insurance law.

The last phrase, "* * * infest the Halls of Congress," is a deliberate falsehood. An attempt is made to create the impression that numerous N. P. C. representatives are continuously busy buttonholing Congressmen and Senators. Such a procedure is in direct opposition to N. P. C. policies and methods. The National Physicians Committee strives to accomplish its objectives by making clear to all of the people the meaning and implications of what are considered to be un-American proposals.

Senator Murray states: "It calls itself ethical and claims to speak in the names of great numbers of doctors who unquestionably are. In fact, its operations have always been characterized by a complete absence of ethics. Its utterances are slanderous and it engages in character assassination."

Comment: This is an unqualified misrepresentation of facts. At no time in any of its literature or public documents has the National Physicians Committee descended to personalities with the single exception of Mr. Oscar Ewing in connection with the convening of the National Health Assembly. This exception was apparently justified by subsequent developments, most notable of which is the resignation of Dr. John Studebaker, United States Commissioner of Education. This resulted from Mr. Ewing's political maneuvering. Exhibits 1, 2, 3, 4, and 5 are basic pronouncements of the National Physicians Committee. They deal exclusively with facts and principles.

If there is the sense of character assassination, it exclusively results from consciousness of guilt on the part of individuals who have associated themselves with programs or activities which, if not actually subversive, are in opposition to American ideals and forms.

Senator Murray states: "Just as its letterhead is a bundle of lies, so too is its continued existence a libel on the medical profession of this country and a threat to democratic processes of our Government."

Comment: This is a typical Vishinsky or Goebbels tactic. Copies of the National Physicians Committee letterhead have been distributed in terms of millions of copies. No one has taken the trouble to take any action either to prove that they are lies or in any way to interfere with their distribution. On the other hand, it is a matter of record that on three different occasions the American Medical Association house of delegates, by formal resolution, endorsed the policy and commended the board of trustees of National Physicians Committee. In 1947, individual physicians and dentists contributed more than $300,000 to its treasury. Under such circumstances, Senator Murray's vitriolic accusation appears childishly silly. The keystone to all of NPC's efforts is the preservation of American institutions and thwarting the efforts of collectivists to centralize controls that would destroy or sabotage the freedoms of the people.

Senator Murray states: "But in order to destroy any possibility that Senators on the other side might think my remarks tinged with partisanship, let me quote another characterization of the National Physicians Committee:

" 'The National Physicians Committee has supplied the medical profession and the public with sheer buncombe—its publications are misleading—it is an inimical force working against the medical profession from within.'

"Those statements were made, Mr. President, not by a proponent of national health insurance, but by Dr. Shearon."

Comment: In 1946 Marjorie Shearon, for some unexplainable reason, saw fit to attack the National Physicians Committee. We are wholly confident that this attack was based on misinformation or misunderstanding. We have no intention of entering into any controversy with Dr. Shearon. It can be said, however, that intemperate as were her statements in connection with the National Physicians Committee in 1946, she has far more vigorously attacked the proponents of compulsory health insurance and the philosophy underlying the moves toward the political distribution of medical care in this country.

Senator Murray states: "Inexplicable is the fact that when the firm of Raymond Rich Associates was employed as public relations counsel to the AMA, and offered to investigate and give a report on the National Physicians Committe for the nominal fee of $5, the offer was refused by officers of the AMA."

Comment: Senator Murray calls Raymond Rich Associates "a reputable public relations firm." He cannot understand why the AMA refused to purchase a $5 investigation. Raymond Rich Associates did submit a report to the board of trustees of AMA on "relations with NPC." However, although seething with denunciation, it was based wholly on hearsay evidence. There was not even the pretense of legitimate investigation. During the term of employment of Raymond Rich Associates by the AMA, no single individual connected with the Rich agency interviewed or questioned anyone officially connected with the National Physicians Committee. They did not ask for one record or one shred of information on which to base their conclusions.

Following the receipt of this irresponsible report of Raymond Rich Associates, the AMA assigned to its committee on executive session the task of investigating the program and the methods of the National Physicians Committee. This study and investigation covered a period of 12 months. The report of this committee was read to and accepted by the house of delegates of the AMA. It included the following statement, which was approved:

"Among those who were familiar with the organization, the general impression was that it was just about the only thing that had stood between the medical profession and political control. In reply to the Rich statement, our answer would be that we have found no responsible party who has had anything derogatory to say about NPC.

"Concerning 'gross inaccuracies and other inappropriate contents of the committee's publications' the worst that can be said is that certain statements and activities might not have been dignified or appropriate had they emanated from the scientific body such as the AMA, but were not unethical or out of line for agents trained in the technique of combating vicious or unfavorable legislation."

Senator Murray states: "That other implications as to the National Physicians Committee 'are to be found in the strange jugglery of funds' as between the National Physicians Committee and Medical Services Foundation."

Comment: In September of 1946, no one—without exception—knew the meaning or the implications of the new Public Law 601. Inasmuch as NPC operations were, to a very large extent, devoted to research and educational efforts, it was, at that time, felt that the activities should be divided into two distinct types of effort. After 14 months of experimentation the undesirability of conducting two separate operations became apparent. For this reason, Medical Services Foundation was dissolved.

Senator Murray states: "Finally, I should like to say that I am considerably perturbed to find pharmaceutical manufacturers contributing to this so-called physicians' committee. It is possible that they did not investigate NPC themselves, but merely accepted the AMA's endorsement of it as sufficient guaranty of an integrity which does not exist. It may be that the AMA grant of approval to certain drug products has a bearing on the matter. Or it may be that a third explanation which has been suggested to me is the true one. However, this latter suggestion would be so damaging to the reputations of these establishments and perhaps to the sale of their products that its disclosure would be most unfair unless its truth was established."

Comment: These are vile insinuations. They are not only despicable but cravenly cowardly. The facts are a matter of record. The leading pharmaceutical manufaituring concerns gave support to the National Physicians Committee operations as far back as 1939. Each and every year since these leading ethical pharmaceutical concerns have contributed to the support of the operations of the NPC. They have had, over a period of nearly 10 years, regular reports on finances, policy, and operations. They understand that the political distribution of health services would quickly lead to political control and distribution of drugs and medicines. They fully comprehend that the socialization of health services and drugs and medicines would foreshadow the socialization of all professions and all industry and would destroy utterly the freedom of enterprise system and the American way of life. They have a direct interest in maintaining our system of private enterprise. They have an equally laudable interest in efforts to maintain our effective American institutions.

Senator Murray states: "Now, to the everlasting shame of honest and conscientious doctors throughout the country, this depraved group, in their names, has reached a new low and is attempting to bribe the cartoonists of America and thereby to buy the editorial opinions of the Nation's press."

Comment: This accusation is sheer poppycock. The National Physicians Committee offered a series of prizes to cartoonists of American newspapers and magazines. An editorial writer on the trade press publication, Editor and Publisher, in its issue of March 6, 1948, saw fit to attack the National Physicians Committee for this offering of prizes. The editorial writer of this publication recommended: "The American Society of Newspaper Editors and all editors should take a firm stand against such contests."

The American Society of Newspaper Editors met in Washington, D. C., during the week of April 15. Pressure was brought to bear to have them act in opposition to the National Physicians Committee's contest. Despite repeated efforts, the ASNE considered the issue of such slight importance that they refused to take any action or make any recommendation.

In like manner the National Editorial Association, meeting in Asheville, N. C., May 6–9, also refused to even consider the matter.

National Physicians Committee's reply is embodied in an Editorial to Editors published in Editor and Publisher. NPC stated and states:

"We believe that the bribery intimation by Editor and Publisher is strange, indeed, if not actually puerile. It is unthinkable that the editorial policy of self-respecting newspapers even remotely could be affected by $3,000 in 14 awards open to thousands of newspapers. * * * Our objective in offering cash awards to cartoonists is clear-cut and definite. The exclusive purpose was to stimulate those who believe as we believe on this issue and to encourage efforts that may result in clarification and understanding. There is an urgent, desperate need for explanation that will make possible accurate appraisal."

The full text of this reply is embodied in exhibit 5 attached to this document.

In closing this statement the belief is expressed that small contribution to the solution of the health care distribution problem will be made by the childish, vindictive diatribe of Senator Murray, which obviously was prepared by paid zealots promoting a system wholly alien to American concepts. These rantings bypass logic and argument and with mere innuendo and invective seek to discredit, and if possible, destroy an effective agency devoted to preserving American concepts and the freedom of enterprise system.

Actually the solution of this problem demands calm and dispassionate analysis and reasoning. To a very large extent the point of view promoted by Senator Murray and the bureaucrats who have used him to promote an un-American program was based almost exclusively on the "draft rejection statistics." Evidence before the Subcommittee on Health of the Senate Committee on Education and Labor in June of 1946 completely exploded the validity of the statistical data and the conclusions reached through false analyses. (See exhibits III and IV.)

It should be kept in mind that almost continuous hearings of the Senate Committee on Education and Labor in 1946 and the Subcommittee on Health in 1947 and 1948 led, after thousands of pages of testimony, to the unanimous conclusion of the members of the Subcommittee on Health, including Senator Murray, that further study was essential. This is evidenced by the submission and acceptance of Senate Resolution 249, as follows:

"*Resolved*, That the Senate Committee on Labor and Public Welfare is hereby authorized and directed through the Subcommittee on Health of the said committee to—

(a) Continue its study of the health problems of the Nation and of legislative proposals relating thereto which have been referred to the said subcommittee, which study shall be primarily concerned with ascertaining the full extent and nature of existing national health problems and the action, if any, which the Federal Government should take in relation to said problems * * *

Notice is hereby served that National Physicians Committee, within strictly legal limits, to the full extent of its ability, its resources, and its organized strength, will continue to—

(1) Advocate, develop, and actively promote means and methods, within the framework of our freedom of enterprise forms and standards, for providing the widest possible distribution of effective health services for all of the American people.

(2) Unqualifiedly oppose compulsory health insurance and the political distribution of medical care.

This pledge we make because America provides more people and a higher percentage of people with a better quality of health care than any other nation in the world. Compulsory health insurance, beyond the possibility of doubt, would require a system which would regiment physicians, dentists, and all of the American people and would centralize controls that would destroy our freedom of enterprise system and our American way of life.

NATIONAL PHYSICIANS COMMITTEE FOR THE EXTENSION OF MEDICAL SERVICE.

[An editorial to editors from Editor and Publisher, March 20, 1948]

EXHIBIT 1. SOCIALIZED MEDICINE AND COMMUNIST PURPOSE

"Men have been sometimes led by degrees, sometimes hurried into things which, if they could have seen the whole together, they never would have permitted the most remote approach."—EDMUND BURKE.

If essential to understanding, the American people should be atomic-bomb-blasted into a consciousness of the meaning of so-called socialized medicine. So systematic and persistent have been the efforts of its sponsors and so adroit and misleading has been the propaganda that the people are becoming inured to the acceptance of a compulsory sickness insurance tax. Socialized medicine is a key mechanism of the Communists for the conquest of this Nation. The menace is immediate. The danger is of today. Socialized health care was not designed to provide better medical care for more people. Always it has been adopted and used to create economic dependence and consolidate political control.

There is a chronology that provides conclusive evidence. Prince Otto von Bismarck invented compulsory sickness insurance. He introduced it in Germany in 1883. By 1892, it covered all workers and most dependents. The purpose was to place the masses of the people under obligation and render them subservient to the state. Afterward the bureaucratic machinery erected became the greatest single strength for Adolf Hitler in his ruthless rise to power.

Lloyd George, in 1911, introduced a somewhat similar system in Great Britain for the same purpose. Its inadequacies and its relative ineffectiveness led to the necessity for extension and the enactment of a "free" medical-care-for-everybody law. Against this law British physicians have rebelled.

Compulsory sickness insurance became a major plank in the platform of the International Labor Organization in 1927. The leaders of Russian communism adopted the system. In 1930 the Communist International adopted this mechanism as a key issue in their program for world revolution.

The International Workers Order[1] is the Moscow-dominated Communist Party agency assigned the task of forcing the issue of compulsory sickness insurance. Under instructions, leftist representatives in labor unions became the crusaders. Through their influence and pressures, endorsements were secured from AFL, the CIO, and PAC. The so-called liberal fronts within the medical profession--namely, the Committee for the Nation's Health and the Physicians Forum became active lobbyists and propagandists. So-called progressive Senators and Congressmen were "sold" and welcomed the opportunity of sponsorship—Senators Murray, Pepper, Chavez, Taylor, McGrath, and Representative Dingell, of Michigan. The Bureau of Research and Statistics of the Social Security Board provided the inspiration, the manipulated statistics, the literature, the propaganda, and the bills for introduction in Congress.

The United States officially became a member of the ILO in 1934. This membership entailed a responsibility on the part of representatives of member nations to "use their efforts and influence to extend social insurance—including sickness insurance—through the exertion of pressure on legislative bodies." In this manner there was established a bureau of the Federal Government pledged to the promotion of a device that is considered to be the most potent single instrument in the program of the Communists for "world conquest."

Since 1935 representatives of our Social Security Board have been active in the development of the ILO, serving as directors and members of its executive committee. The extent to which they have gone to impose this strictly totalitarian concept on the people of the United States is now a mater of official findings by a committee of the Congress.

Excerpts from the third intermediate report of the Committee on Expenditures in the Executive Departments read:

"Our first report deals exclusively with activities calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance, and

"Your committee concludes from the testimony that most, if not all, of this literature distributed by the CIO, the AFL, the Farmers' Union, and the Physicians Forum originates in, and emanates from the Bureau of Research and Statistics in the Social Security Board, and

"Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."

There is no dearth of evidence. It is conclusive. The sequence—Germany, England, the ILO, Russia, Communist International, the Communist Party of the United States, the International Workers' Order, the Social Security Board, the AFL, the CIO, the PAC the Committee for the Nation's Health, the Physicians Forum, the Farmers' Union and scores or even hundreds of front organizations that are used in the over-all efforts.

There are in this country sincere, responsible, truly patriotic American citizens who, with unimpeachable motives, lend their positions and their substance to the promotion of compulsory sickness insurance. They do not comprehend. Actually it is merely a device for centralizing and consolidating political control. It is an instrument of world revolution leading to Communist conquest.

---

[1] General offices, 80 Fifth Avenue, New York 11, N. Y.

The people do not know this. They should be told. The editors of newspapers should tell them.

NATIONAL PHYSICIANS COMMITTEE FOR THE
EXTENSION OF MEDICAL SERVICE,
JOHN M. PRATT, *Administrator.*

[An editorial to editors from Editor and Publisher, March 27, 1948]

EXHIBIT 2. POLITICAL MEDICINE AND MORAL DETERIORATION

The distinguished scholar, economist, lecturer, author, and war correspondent, Melchior Palyi,[2] wrote the Chicago Tribune under date of February 23, 1948. There was concern and urgency in this letter based on experience, knowledge and understanding. It was published in The Voice of the People on March 8, 1948, under the heading "Corruption by Socialized Medicine." It is reproduced herewith:

"CHICAGO, February 23.—Some 86 percent of Britain's doctors have voted against participating in the socialized medicine system proposed by the Labor government.

What interests us in this country is the question whether socialized medicine is good or bad—how it works. As one who has seen and studied the world's first, most elaborate, and best organized governmental system of medical service in actual operation, this writer cannot help but express his sincere respect for the British doctors' intellectual courage. They do not only expose themselves to the wrath of the all-mighty Labor government of their country, but actually refuse to accept what amounts to an extraordinary bribe. That is what socialized medicine amounts to: a legalized system of corruption and bribe, as the German example of its operation over a long period of years has shown.

Compulsory general health insurance may operate under one of two schemes. Either the patient is "allocated" to one or to a few specified doctors or he has the choice among all the doctors who have signed up with the system.

In the latter case—with free choice among the doctors by the patient—here is what developed in Germany and what is to be expected in England and everywhere else. All but a very few doctors must sign up with the insurance scheme; they must do so because everybody being a member of the scheme, and having to pay his or her contribution, prefers to get free medical service, rather than to pay for it. That gives the doctor a more or less secure existence at low fees but at a high rate of "turn-over." Moreover, the doctors need not compete with one another in terms of quality and service.

Actually, a new kind of competition arises, to the detriment of the patient, of justice, and of the health scheme's finances. To get more income—nay, to get a decent income out of the low fees on which the scheme naturally is being operated—the doctor is interested in getting as many patients as possible. As he gets the more patients the "nicer" he is, the more willingness he shows to declare the patient ill and to provide him thereby with a sick leave as well as with cheap (or free) medications.

In Germany quite a few doctors misused their positions in the scheme by being liberal to the clients and having as many as 100 patients visit their offices each day. The quality of their professional service deteriorated accordingly. A workingman who wanted to have a day off would go to his doctor's office saying he had a headache, get a prescription for an aspirin and a statement from the doctor that he was unable to work that day. If the doctor refused, the patient's freedom of choice permitted him to shop around until he found the cooperative kind of doctor.

---

[2] Palyi, Melchior, economist; b. Budapest, Hungary, March 14, 1892; s. Edward and Marie Palagyi; ed. gymnasiums, Hungary and Switzerland, schls. of commerce, Frankfort and Munich (Masters degree, 1912), univs. of Geneva and Munich (Doctors' degree, 1915); m. Raissa Rubuch, of Russia, June 25, 1926, elk, Nat. Bank, Bremen, Germany, 1915–16; rep. of Austro-Hungary Bank and Hungarian Ministry of Agr., 1917; teacher in bus. schs. and univs., Munich, Goettinger, Keil, Berlin, 1918–22; visiting prof., U. of Chicago, 1926–27; chief economist, Deutsche Bank, Berlin, 1928–33; mng. dir., Currency Research, Inst., Berlin, and adviser to Reichsbank, 1931–33; editor, Monetary Economy, monthly, Berlin, 1931–33; founder and mem. bd., German Free Economy League, German Savers League, Berlin, 1932; guest economist, Midland Bank, London, and lecturer, Univ. Coll., Oxford, 1933; visiting prof. and research economist, U. of Chicago, 1934–37; economist, Stifel, Nicolaus and Co., investments, St. Louis and Chicago, 1937–40; lecturer, Northwestern University, 1940; visiting professor, University of Wis., 1940–42; company of Illinois since 1940; financial adviser to several instns.; lecturer, and radio commentotor. Author of numerous books and articles on econ., polit., and financial subjects in both German and English. War corr. in Europe for Detroit News, 1945.—From Who's Who in Chicago and Illinois.

A fantastic corruption developed that wrecked the finances of the health-insurance scheme and created constant deficits which had to be filled at the taxpayers' expense. A decent and conscientious doctor, on the other hand, languished in lack of patients.

Without the patient's freedom to choose his doctor, compulsory health insurance means medical slavery rather than free medical service. With free choice it means the invitation to wholesale corruption.

MELCHIOR PALYI.

The Wagner, Murray, Pepper, Dingell proposals would rob the physician of his freedom of action and decision. They would render him subordinate to a bureaucrat. Bureaucratic control would destroy the intangible, indefinable essence that is the secret of the American doctor's effectiveness. These things the American people should know. It is believed that editors of American newspapers will tell them.

NATIONAL PHYSICIAN'S COMMITTEE FOR THE
EXTENSION OF MEDICAL SERVICE,
JOHN M. PRATT, *Administrator.*

[An editorial to editors from Editor and Publisher, April 3, 1948]

EXHIBIT 3—DECEITFUL MANIPULATION OF DRAFT STATISTICS

"The amazing ramifications of the Federal propaganda in behalf of socialized medicine have astonished me. All of this federally financed activity heads up in the Bureau of Research and Statistics in the Social Security Board. Our committee investigators have found in that Bureau a veritable nerve center of socialized medicine propaganda for the entire world."—The honorable FOREST A. HARNESS.[3]

The Social Security Board of the Federal Security Administration, almost exclusively has confined its research and propaganda to efforts "calculated to build up an artificial federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance."

Adolf Hitler is credited with the postulate that "the greater the untruth, if it be often enough repeated, the more apt it is to be accepted." On such a basis the Social Security Board's case for the need of compulsory health insurance has been built. There were two major premises that continuously and systematically have been used to win converts to their cause:

(*a*) That 36 percent of all eligible young men examined by selective service boards were found to be physically unfit for military service.

(*b*) That one-third of the people, those in the low-income group, were more subject to sickness and were unable to pay for adequate medical care.

Initially the medical profession was shocked—stunned—by the possible implications of the 36 percent rejection figure. The propagandists for socialized medicine used it in limitless forms, through all of the agencies that could be mobilized, as evidence of the ineffectiveness and unavailability of American medical care. So far-reaching and so persistent were these efforts that many well-meaning people came to accept the findings as accurate and conclusive.

The ranks of the medical profession are filled with free men with fearless and inquiring minds. It fell to the lot of one of these—Maurice H. Friedman, M. D., an internist of Washington, D. C., to expose the unscrupulous manipulations of statistics that led to these false and dangerous conclusions. He made crystal clear their real meaning. Testifying before the Subcommittee on Health of the United States Senate Committee on Labor and Public Welfare, Dr. Friedman said:

"Between December 7, 1941, and December 31, 1943, the draft boards selected about 10,000,000 men for examination, and of these about 3.6 million were rejected; i. e., a rejection rate of about 36 percent. During this period, however 2.7 million men voluntarily enlisted in the armed forces.

---

[3] Chairman of the Congressional Subcommittee of Publicity and Propaganda of the Committee on Expenditures in Executive Departments.

"If these men had gone through the selective service examination, the total number of men examined would have been 12.7 million, and the rejection rate 28.4 percent."

He then pointed out that 20 percent of rejections (20 percent of 28.4 percent or 5.68 percent of total men) were for conditions not medical, among which were illiteracy, mental deficiency, and syphilis (a social disease), etc.

This reduced the possible medical rejection rate to 22.7 percent.

Dr. Friedman then listed diseases or conditions that were not preventable and not remediable among which were mental disease, heart conditions, congenital defects, defective vision, overweight, underweight etc. These accounted for approximately 45 percent of the total rejections (45 percent of 28.4 percent or 12.78 percent total men).

This 12.78 percent deducted from the 22.7 percent left a possible medical care rejection rate of 9.92 percent.

There was a third listing of categories of diseases or conditions that were not preventable but were correctable, among which were: tonsils, varicose veins, hernia, nasal obstructions, defective hearing, teeth, etc., to a total of approximately 16 percent (16 percent of 28 percent or 4.5 percent of the men examined).

Deducting 4.5 percent from the previous total left rejections, having possible medical care implications, of 5.42 percent of the millions of men examined by draft boards.

There were tens of thousands of duplicate rejections. There were logical explanations of other classifications. The facts from the figures indicate that only a fraction of 1 percent of total rejections could have resulted from the unavailability or the cost of medical care.

Dr. Friedman said, in effect—Under no circumstances, with the worst possible interpretation, can the selective service rejections be considered an indictment of the medical profession or the quality and availability of medical care in this country. Actually never before has such conclusive evidence been provided of the universality and the effectiveness of America's health service. Millions of men were paraded before the selective service boards. There were men with one hand or one leg, some with arrested cases of tuberculosis or diabetes, others with puncturd ear drums or one eye. These men, though incomplete, were active, useful human beings. They were men—not corpses in graveyards due to medical inattention. One and all they were the living testimony of the availability of medical care and the competency of American physicians.

Hence. the 36 percent of rejections by selective boards dwindled, on the basis of Dr. Friedman's analysis, to less than 1 percent traceable to any failure of medical service. However, the 36 percent has been trumpeted to the gullible and unsuspecting as the key argument of the necessity for compulsory health insurance.

When understood the draft rejections provide the most convincing evidence ever adduced of the value and superiority of America's system of medical care distribution. For these facts explanations and this clarification, the American people owe to Maurice H. Friedman, M. D., a debt of enternal gratitude.

These things the people should know. It is believed that because of the life and death fight now underway to preserve our freedom of enterprise institutions, the editors of newspapers will tell them.

NATIONAL PHYSICIANS COMMITTEE FOR THE
EXTENSION OF MEDICAL SERVICE,
JOHN M. PRATT, *Administrator.*

[An editorial to editors from Editor and Publisher, April 17, 1948]

EXHIBIT 4. LOW INCOME GROUPS AND MEDICAL SERVICE

> The American people have a priceless heritage. It belongs exclusively to the people of the United States. This heritage stems from a tradition and sensing of freedom which antedates by centuries the establishment of this Nation and the adopting of its written Constitution. Its tangible expression is embodied in the private-enterprise system. The essential to its preservation is the sanctity of the human personality—the supremacy of the individual and the subordination of the state.[4]

---

[4] The Priceless Heritage, an NPC publication.

There is under way an aggressive, determined, relentless drive to foist on the people of this country a compulsory health-insurance tax. There is no need for dependence on theory or opinion as to the ultimate result. History provides the evidence. Free-enterprise institutions cannot survive the establishment and operation of such a system.

There are two key suppositions on which the proponents of compulsory health insurance base their case:

(*a*) That draft rejections demonstrated the inadequacy of American medicine and our system of health care distribution.

It has been shown that less than 1 percent of such rejections could have been traced to the unavailability or the cost of medical care.

The summary of a report resulting from the comprehensive study by the staff of the Brookings Institution was released on February 17. With reference to the "so-called draft statistics," it states: "They are unreliable as a measure of the health of the Nation and cannot be used to show the extent of the medical needs of the country as a whole."

(*b*) That one-third of the people—those in the low-income group—are most subject to sickness and are unable to pay for adequate medical care.

The humanitarian instincts and urges of the American people are real and insistent. If the case can be made that there is lack of health care—due to inability to pay for service—and that such service can be provided through compulsory health insurance, it is contended by the proponents that we should turn over to minions of the Federal Government the delicate and vital task of distributing health-care services. The adoption of this strictly collectivist mechanism can lead only to disaster.

Scores of tables of statistics are quoted by the promoters of nationalized medical care. The purpose of all of these is illustrated by a single instance—namely: Those earning $2,000 per year annually receive 2.045 doctor calls, while those earning $5,000 to $10,000 annually have the doctor call 3.6 times each year.

In his historic testimony, Maurice H. Friedman, M. D., provided evidence—clear and uncontestable—that the case for lack of medical care for the low-income group is built on a wholly false premise. There is no static under privileged low-income group in this country.

This is a Nation of workers. Earnings and incomes are a matter of continuous progression. There are daily changes of income status—actually hourly variations when the total of more than 60,000,000 workers is considered. Consequently, among the tens of thousands of tables of statistics there are no known reliable tabulations that deal with incomes by age groups.

While there is an absence of statistical tabulations, common knowledge and judgment provide accurate and wholly convincing conclusions. When viewed in proper perspective, the facts become self-evident. It is urgent and of the most vital importance that they be understood.

Income group classifications result from tabulation of the earnings of the individuals. Teen-age workers earn less than workers with some experience. Higher earnings accrue through additional experience or improved skills. Always young people constitute a predominant percentage of individuals in the so-called low-income group.

The tabulations and the chart opposite are neither final nor conclusive. However, they are rare and factual. Their importance lies in the evidence they provide of a universal progression. In the trades this process brings the worker to maximum earnings in his fifties; in business and the professions at an older age. The component parts of wage group classifications are constantly changing. Medical service is provided for individuals. It cannot be related to a "group" or "groups" that are subject to continuous variations.

There is another body of related facts that provides the final convincing evidence.

During the last 50 years, typhoid fever, diphtheria, smallpox, tuberculosis, pneumonia, and other killers of youth have been brought under control. Heart ailments, cancer, and other degenerative diseases now take foremost place as the dread killers of men. As young people are moving forward in the progression toward larger earnings and higher incomes, they are less subject to fatal illness. During this period there is less need for medical care. In a direct ratio with age. human beings become subject to attack from the fatal diseases of men.

It can be simply stated: Young people earn modest incomes; mature people earn more; older people earn most. Young people are less subject to fatal diseases—need less care. As they become older they are more subject to attacks of killing diseases. They must have medical care if life is to be preserved.

American medicine and our system of its distribution is conquering disease. In 50 years the cumulative effects are startling—almost incomprehensible. The average life expectancy has been increased 16 years—from 50 to 66 years. In this country in 1900 there were 3,000,000 people 65 years old or over, or 4.1 percent of the population. In 1945 there were 10,000,000, and represented 7.2 percent of the total population. American medicine has prolonged the lives of younger people. It has moved them into an age group where more care is needed. Simultaneously they have progressed into earning levels that enable them to pay for the necessary additional service. These are the facts.

Our vital task is to preserve the priceless heritage of the American people. No compromise dare be made on the issue of compulsory health insurance. Socialized health care was not designed to provide better health care for more people. Always it has been adopted and used to create economic dependence and consolidate political control. Always it will be so used.

These things the people should know—editors with courage and convictions should tell them.

National Physicians Committee for
the Extension of Medical Service,
John M. Pratt, *Administrator.*

[An editorial to editors from Editor and Publisher, April 10, 1948]

Exhibit 5. Anent Cash Awards for Cartoonists

"The lady doth protest too much, methinks."—Hamlet.

The National Physicians Committee announced in a full-page advertisement in Editor and Publisher's issue of February 28: "Cash Awards to Cartoonists" in 14 amounts totaling $3,000.

The first rule of the contest stipulated that applications for entering the contest must have the approval of the "publisher." This is the evidence that there was no desire to influence the editorial policy of any publication.

A newspaper in an Ohio town took violent exception to the proposal. In a near-column-length editorial, it announced that its cartoonist would not enter the contest, and said: "The reason is simple. Space on our editorial page is not for sale." Was such an announcement necessary? The editorial further stated: "More than that, we shall ask our cartoonist, Mr. White, to refrain from drawing any cartoon on this subject during the 3 months of your contest." Under certain conditions, not doing is as reprehensible as a sin of commission. If the homestead is in flames, a fire extinguisher should be used.

Editor and Publisher in its issue of March 6 publishes a story devoted to the editorial in the Ohio town newspaper. Also from its Olympian heights it wigwagged an alert to all editors of all newspapers in the form of a column-length editorial. It said in part: "The contest rules leave no doubt that this is a subtle bribe to cartoonists to support or oppose certain political beliefs." The word "bribe" is a harsh term.

A cartoonist for a Minneapolis newspaper—who presumably read this editorial comment—published a graphic illustration March 11 expressing his indignation. Editor and Publisher, in its issue of March 20, reprints the Minneapolis newspaper cartoon and the comment and carries a three-quarter-column editorial again warning editors and cartoonists.

It is difficult to understand the persistency of this questioning. Almost it would seem that Editor and Publisher is fearful of the venality of some and maybe a shade overzealous in its determination to protect the virtue of others.

This is America. In this country issues are clarified through controversy. It is the land in which as yet differing opinions can be expressed without fear. That all do not think alike on this issue is evidenced by letters now in our files. An editor wrote:

"I understand perfectly about your cartoon contest and am in favor of it. In fact, when you talk to this newspaper, you are talking to convinced Christians who believe the same way you do about the evils of nationalized medicine. To show that we do, I enclose a cartoon which I would like to enter in your contest."—Editor.

A publisher wrote: "I feel that you are entitled to the wholehearted cooperation of every newspaper which is dedicated to the perpetuation of our democratic system of government. With kindest regards, believe me to be most sincerely yours."—Publisher.

These two letters clearly indicate the thinking and the attitude of scores of editors and publishers.

It is understood and accepted that in this ethical controversy a mere layman could not express a useful opinion. However with real humility and after consultation, the belief is expressed that the American people expect and have a right to demand two things from their newspapers:

1. Objective reporting and uncolored news stories covering events transpiring throughout the world.
2. Editors with convictions who explain issues and fearlessly espouse causes in keeping with their beliefs.

Such editors, in these times of deadly peril, are essential to self-preservation.

Tomorrow, we may be faced with the horror and devastation of atomic, global war. In times of such stress, cherished institutions are destroyed and freedom-gains, the result of centuries of effort, may be forfeited. These can be affected by both foreign and domestic policies.

Implicit in the program of the national administration are so-called social gains for the people. Actually some of these are measures of reaction and retrogression. The most dangerous and menacing item on the agenda is compulsory health insurance—providing for the political distribution of health services in this country. England, today, is the tragic victim of the cumulative effects of such procedures. The inadequacies of a panel system led to the enactment of a "free medical care for everybody law." British physicians have refused to attempt to practice medicine under the provisions of this statute. Free-enterprise institutions cannot survive the establishment and operation of such a system.

Any steps, within the limits of propriety, are justified that will aid in preserving our Christian concepts and perpetuating our American way of life—lest we meanly lose the last best hope of earth.

We believe that the bribery intimation by editor and publisher is strange indeed—if not actually puerile. It is unthinkable that the editorial policy of self-respecting newspapers even remotely could be affected by $3,000 in 14 awards open to thousands of newspapers. If this were true, Vishinsky's vitriolic diatribes against the "capitalistic press" could be understood.

Our objective in offering cash awards to cartoonists is clear-cut and definite. The exclusive purpose was to stimulate those who believe as we believe on this issue and to encourage efforts that may result in clarification and understanding. There is an urgent, desperate need for explanation that will make possible accurate appraisal. Never again should there be too little—too late.

To the intrepid, clear-thinking editors and cartoonists, who are aiding in the accomplishment of this clearly defined purpose, we tender our thanks and our appreciation.

National Physicians Committee for the
Extension of Medical Service,
John M. Pratt, *Administrator.*

Health Insurance Plan of Greater New York,
New York 11, N. Y., June 3, 1948.

Hon. H. Alexander Smith,
United States Senate, Washington, D. C.

Dear Senator Smith: Mr. Dorr has told me that he has spoken to you recently about the various problems the Health Insurance Plan of Greater New York has been facing in its development. Although we feel that we have made substantial progress and are well on the way toward achieving a demonstration of the fact that comprehensive medical care of high quality can be provided for families of modest and low income through a voluntary prepayment plan, we face obstacles from time to time which might be of interest to you and which I thought you might wish to put in the record of your committee's studies before they are closed.

The enclosed clippings from the New York Times and the New York Herald Tribune relate the recent action of the New York State Medical Society which we very much regret. Also enclosed is a statement made by Dr. Rappleye in regard to this action and copies of editorials which appeared in these newspapers and in the Watertown Daily Times with respect to the State society's action.

The question will naturally arise in your mind as to why the New York State society does not approve the HIP. The principal difficulty lies in the fact that under the standards of the State society for the approval of voluntary insurance plans, the governing body of the plan must contain a majority of physicians and these physicians must be recommended by the State medical society. A copy of the State society's standards for approval is attached. The organizers of HIP feel that the organization is a community enterprise which is, in effect, a banding together of families of modest and low income for the purpose of purchasing comprehensive medical care of high quality. As such, the plan should, in the view of HIP's incorporators, be under the control of community representatives including a strong representation but not a majority of physicians. So long as the HIP adheres to this principle which it feels to be exceedingly important, it cannot be approved by the New York State Medical Society unless, of course, the society should change its rules for approval. The HIP is proud of being a community organization and feels that organized medicine is mistaken in its view that voluntary insurance plans should be exclusively under the control of the profession.

It should be recognized that the lack of State society approval in no way reflects upon the standards of quality of the medical services offered by HIP. Indeed, the society's rules for approval make no mention whatever of medical standards. HIP's professional standards are guaranteed, in the first place, by the outstanding physicians who serve on its board of directors, a list of whom is attached. Whereas HIP regards the general policy of its program and organization as properly a matter of community interest, it feels equally strongly that physicians should have unquestioned control over all professional matters. For this reason, HIP has appointed a medical control board composed entirely of physicians and including representatives of county medical societies, the New York Academy of Medicine, the physicians of the HIP board of directors and of the participating medical groups, which establishes and supervises the maintenance of professional standards and in general is in control of all professional aspects of the program. In this connection it should be noted that organized medicine in New York City was offered majority representation on HIP's medical control board. In spite of the fact that written agreements with HIP were made by all the county medical societies to provide such majority representation on its medical control board, and in spite of repeated assertions by organized medicine that its primary concern in an insurance plan is to guarantee to the public that high medical standards are maintained, the medical societies here have for over a year failed to take advantage of the opportunity offered by HIP to assume control of the professional aspects of its program.[5]

I should add that HIP's bylaws provide that its medical control board may be overruled by the board of directors in a professional matter only with the concurrence of a majority of the physicians of the board of directors. Thus, in respect to medical matters, final control of the Health Insurance Plan rests entirely with physicians.

We believe that this division of instruction is a proper one and that in the public interest a program in which the health of the subscribers is at stake, and which is supported from the premiums paid by subscribers and their employers, should be controlled by community representatives.

This issue of the type of controlling organization best suited for a voluntary medical insurance plan has arisen in many parts of the country and has frequently resulted in difficulties for various groups such as employers, trade unions, cooperatives, fraternal organizations, etc., which have sought to develop prepayment plans for their employees or members. Recently there have been indications that this problem and several others may be jointly discussed by the representatives of the medical profession and of groups such as I have mentioned, in an effort to reach a better understanding and possible agreement. If this can be accomplished it will be an important step forward in the development of satisfactory voluntary medical insurance plans. If these plans are to grow in size and in scope of service to a point where they can be of maximum usefulness to the public, it seems to us that experimentation with different methods should be encouraged rather than obstructed, and that only through such experimentation can we hope to reach sound conclusions as to the methods best adapted to promote satisfaction for both the professions and the public.

Senator Murray's office has also indicated interest in this recent incident regarding HIP, and I am taking the liberty of sending the same material to him.

---

[5] The medical societies of New York, Kings, and Richmond Counties and the New York Academy of Medicine have sent representatives to the medical control board. The medical societies of Bronx and Queens Counties and the coordinating council of the five county medical societies have not sent such representatives. Representatives of organized medicine now on the medical control board, therefore, are less than half of the total number of 11.

If you would care to have further information about the program and about the problems we have faced, I shall be happy to meet with you at your convenience or to send you a more detailed report.

With kindest regards.

Sincerely yours,

DEAN A. CLARK, M. D., *Medical Director.*

STATEMENT BY DR. WILLARD C. RAPPLEYE, CHAIRMAN, BOARD OF DIRECTORS, HEALTH INSURANCE PLAN OF GREATER NEW YORK

It is regrettable indeed that the New York Medical Society should record opposition to the efforts of physicians, hospitals, industry, the city of New York, national organizations, and other groups to establish and provide adequate modern medical care for the community. The action of the State society is against the public interest.

It is evident that the society has diregarded the advice it was given by Mr. Bernard Baruch a few months ago when he said "too many doctors have been fighting a rear-guard action for too long."

The Health Insurance Plan of Greater New York, one of the numerous plans the society has advised its members not to join, by offering an opportunity to persons of moderate means to prepay for comprehensive medical service through group practice, is making it possible for the people of New York to get high standard medical care as a preventive measure and as complete treatment for their illnesses and injuries. Since employers pay half the costs in this plan, it is possible for a great many people to join who otherwise would have to rely on public, private, and professional charity for their medical care. Ours is the self-respecting way to pay for medical service; this is the method for reducing the taxpayers' burden.

This action by the society disregards, too, the conclusions reached by the planning committee of the medical care section of the recent National Health Assembly in which national representatives of the public and the professions took part. These conclusions were that "voluntary prepayment group health plans, embodying group practice and providing comprehensive service, offer to their members the best of modern medical care. Such plans furthermore are the best available means at this time of bringing about improved distribution of medical care. * * * Hence such plans should be encouraged by every means."

HIP is designed to provide comprehensive medical care on a prepayment basis for this community and will continue to expand its program. We are confident that the people of New York will continue to support this plan and the doctors who are participating in it.

[Excerpt from the New York State Journal of Medicine, July 15, 1947]

DEPARTMENT OF MEDICAL CARE INSURANCE

Conducted by George P. Farrell, Director

STANDARDS FOR APPROVAL BY MEDICAL SOCIETY OF THE STATE OF NEW YORK OF VOLUNTARY NONPROFIT MEDICAL CARE PLANS IN NEW YORK STATE

Local approval

1. Approval of the county medical society in whose area a plan operates.
2. In the event a county society does not approve a plan, a special committee of three members be appointed—one by the plan, one by the county medical society, and one by the Medical Society of the State of New York—to investigate and study the reasons for withholding approval.
3. If, in the opinion of a majority of the committee, after consideration, approval will be granted to the plan.

Professional control

1. The governing body must contain a majority of physicians.
2. These representatives shall be members of and recommended by the Medical Society of the State of New York.
3. The medical profession is to assume responsibility for the medical services included in the benefits.

Free choice of physician

1. There shall be no regulation which restricts the choice of a qualified doctor of medicine in the locality covered by the plan, who is willing to participate and render service under the conditions established.

2. The method of rendering service must retain the personal, confidential relationship between the patient and physician.

Subscriber benefits

Subscriber benefits may be terms of cash and/or service units.

Claims payments

1. When care has been rendered by a participating physician and claim filed for such care, payment shall be made direct to the participating physician. When subscriber has paid the physician, then payment may be made to subscriber upon presentation of a receipted bill. This method of payment should be discouraged and should apply only in instances where subscriber has paid the physician.

2. When care has been rendered by a nonparticipating physician and claim filed for such care, payment shall be made direct to the nonparticipating physician or to the subscriber upon presentation of receipted bill.

Underwriting

1. Subscriber premium rates should be adequate to provide for the benefits offered and the risks involved in the contract.

2. Plan should be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

3. All plans shall conform with State statutes as set up under the New York State Insurance Department with due consideration for earned premiums, administrative costs, and reserves for contingencies.

Enrollment

Enrollment procedures shall be on a sound basis so as not to expose the plan to adverse selection.

It is recommended that enrollment be offered to individuals at the earliest possible date that experience of the plan warrants.

Promotion

Descriptive folders and all promotional material shall state clearly and accurately the benefits offered by a plan, and also in the same manner, exclusions in the contract.

Reports

All plans which have received approval, or are seeking the approval of the Medical Society of the State of New York, shall submit quarterly reports on forms provided for that purpose to the bureau of medical care insurance of the Medical Society of the State of New York.

Duration of approval

Approval by Medical Society of the State of New York shall be for a period of 1 year, at the end of which review of all plans will be made by an appropriate committee of the Medical Society of the State of New York, to determine eligibility for renewal.

Comment

The subcommittee on medical expense insurance of the council committee on medical economics of the Medical Society of the State of New York has felt for some time that New York State voluntary nonprofit medical care plans should conform, in their general operation and set-up, to certain requirements, in order to be eligible for approval by the Medical Society of the State of New York. The above standards were drafted by the committee approved by the council and adopted by the house of delegates of the Medical Society of the State of New York at its annual session in May 1947. They conform in general to the outline of requirements of the council on medical service of the American Medical Association for approval of such plans by that body, with other necessary additions that were deemed advisable.

The purpose of the standards is to maintain medical control, preserve the established doctor-patient relationship, and aid in accurate promotional material. The filing of quarterly reports by each plan on membership, claims, financial status, etc., with the bureau of medical care insurance of the State society will permit compliation of satistical statements and aid in the establishment of benefits and premiums under sound underwriting principles.

The six plans operating in New York State are approved by the Medical Society of the State of New York and subsequent approval will be granted annually, following a study and review of each plan's adherence to the standards, by an appropriate committee of the State society.

It is the feeling of the medical care insurance bureau that these standards will maintain and further promote the voluntary nonprofit medical care movement and assure continued benefits to the public and the doctors.

[Editorial from Watertown Daily Times, Tuesday, May 25, 1948]

Doctors and Progress

Action of the house of delegates of the New York State Medical Society in objecting to the Red Cross reestablishing its wartime blood donor program has caused concern among doctors in other places besides Watertown. The house of delegates would provide free blood for indigents only.

If the house of delegates has taken this action on the assumption that the amount of free blood will not equal the demand, especially in the large cities, this can be determined after adequate test. It has been the local experience that to depend upon friends and relatives of patients to replenish blood banks has not always been satisfactory. The Red Cross system worked better.

It is not only the action of the house of delegates with respect to free blood that has caused concern, however. That governing body of the State medical society also warned doctors against participating in the Health Insurance Plan of Greater New York. This plan has been operated under the highest medical standards and is directed by eminent medical men. It is entirely on a voluntary basis.

One would think that plans of this kind would be welcomed by medical societies as the most effective means to overcome the growing sentiment for what the doctors call socialized medicine. Instead, however, the house of delegates takes what the New York Herald Tribune calls a step backward.

The more medical societies put obstacles in the way of worthy and reputable voluntary health insurance plans, the greater the demand will be for national compulsory health insurance which most of us would like to avoid if at all possible.

In this county, the Jefferson County Medical Society has gone on record in favor of the Red Cross reestablishing its blood donor service. Tonight a meeting will be held between representatives of the society and the Red Cross in an effort to work out a concrete plan.

[Editorial from New York Herald Tribune, May 22, 1948]

A Step Backward

We had hoped that the reactionary influences which have too long prevailed in this country's powerful medical organizations were going down to defeat. Leaders in the profession have aided and encouraged such hopeful developments as voluntary prepayment plans and group medical practice, dclaring them to be essential to secure better distribution of medical care.

Action by the Medical Society of the State of New York designed to retard promising efforts along those lines is therefore the more disheartening, the harder to credit. The society is now advising its members against participation in any voluntary health insurance plans except those it specifically approves. It thus warns doctors against service in the Health Insurance Plan for Greater New York, to which its approval is not accorded. This plan is operating under the very highest standards of medical care, and is directed by as reputable, and indeed as eminent, medical men as the city has. It offers preventive and comprehensive care to families of moderate incomes. It has not the society's approval because of essentially technical differences, one of which concerns the proper doctor-patient relationship. But since the plan is entirely on a voluntary basis, differences between it and those directly sponsored by the medical society should be welcomed for their potential contribution to better practice.

The society's decision was no doubt influenced by doctors' opposition to socialized medicine—opposition with which we sympathize. We do not sympathize when fear of socialized medicine turns into a bugaboo that routs reason. The certain way to increase demand for national compulsory health insurance is to put barriers in the way of worthy and wholly reputable voluntary plans. The barrier the society now raises is formidable. Doctors are extremely sensitive to the advice of their organized societies because professional advancement may depend upon good standing therein.

We trust that doctors who subscribe to the kind of progress represented by H. I. P. will not be constrained by this probably transient bit of medical society advice. For to the public which they serve it makes no sense whatever.

[Editorial from the New York Times, May 21, 1948]

A Sound Health Plan

The house of delegates of the Medical Society of the State of New York has adopted a resolution recommending that the society advise its more than 22,000 members "not to become participating physicians in any voluntary health insurance plan unless it has been approved" by the society. According to our news report, this resolution is interpreted as an attempt to discourage New York physicians from participating in the Health Insurance Plan of Greater New York.

Probably no system of voluntary health insurance ever developed for this city has been the subject of more careful medical and actuarial consideration than the Health Insurance Plan of Greater New York. The local county medical societies were consulted before the plan was put into effect, to make certain that there was no violation of medicine's ethical code. The late Mayor La Guardia sponsored the plan as one that city employees should support. Mayor O'Dwyer has been equally strong in his endorsement. Three out of five local medical societies and the New York Academy of Medicine agreed to cooperate in experimenting with the plan by appointing physicians to sit on the control board. If the many physicians who are now rendering good medical service under the plan at a cost that thousands in the employ of business firms and the city can easily meet were to follow the society's advice and withdraw, the cause of self-help in health insurance would receive a heavy blow.

The State medical society has a proper professional right to scrutinize any health insurance proposal and to decide whether or not it meets accepted medical standards of quality. It should not imply that the physician who participates in a sound and ethical health insurance plan which may not have come before its courts professional ostracism.

Philadelphia 3, Pa., *February 25, 1948.*

Senator H. Alexander Smith,
Senate Office Building, Washington. D. C.

Dear Senator Smith: Am writing you concerning hearings of the Murray-Wagner-Dingell bill. On page 1535 of part III, the record seems to be incomplete.

As I was chairman of a committee of the house of delegates of the American Medical Association investigating the Rich report, I am taking the liberty of sending you copies of material which was gathered in order to properly evaluate the Rich report. I think in view of the incompleteness existing on page 1535 of part III, that this enclosed report should be added to the record.

Most respectfully,

William Bates, M. D.

[Excerpt from the proceedings of the House of Delegates of the American Medical Association, the ninety-sixth annual session, the centennial celebration, held at Atlantic City, N. J., June 9–13, 1947]

Report of Special Committee on Executive Session for Consideration of Rich Report

Dr. William Bates, chairman, presented the following report:

At the supplemental session of the house of delegates in December 1946 your special committee on executive session for consideration of the Rich Report presented its conclusions, with the exception of that portion pertaining to the

National Physicians' Committee, which it reported needed further study. This committee was again delegated to make this study. High lights of the Rich associates comments on this matter were as follows:

"1. No one whom we have consulted has had anything favorable to say about the N. P. C.

"2. The charges regarding gross inaccuracies and other inappropriate contents in the committee's publications are too widespread to be ignored.

"3. A widespread rumor of unsavory character regarding certain channels through which some of the funds are alleged to flow.

"4. The recent appearance of a committee spokesman before the Senate hearings made, we would say, a highly unfavorable impression.

"5. There appears to the public to be a dubious relationship which we are certain has injured the American Medical Association's public relations.

"6. We recommend. therefore, that no further encouragement or participation in its activities be given to the N. P. C. and that there be under no circumstances any interlocking trusteeship."

Your committee was deeply concerned over these findings and did not feel inclined to pass hasty judgment on these grave statements by a reputable group of public relations experts without documentary or other evidence. Such evidence was not available prior to the last meeting of the house. Mr. Rich promised further study and a subsequent report. No record of any further survey of the National Physicians' Committee by the Rich associates has been filed with this committee. In order to be in a position to make a final report on this matter at the present meeting of the house, your committee has taken the following steps:

1. Careful inspection and study of the financial statement of the National Physicians Committee as compiled by an accredited certified public accountant.
2. Questioning of physicians. legislators, newspapermen, and others by individual members of the committee.
3. Survey at headquarters of the National Physicians' Committee of the type of activities in the past, the present. and contemplated in the future.
4. Survey of the activities of and the progress made up to date by the public relations division of the American Medical Association.
5. Survey of the activities of the Bureau of Medical Economic Research of the American Medical Association.
6. Study of Opinion Research Corporation Surveys and Survey of Public and Physicians on Selected Issues and Report of Psychological Corporation Survey on Public Attitudes.

From these studies, the following facts have been established to the committee's satisfaction:

1. On questioning our colleagues concerning their reaction to the activities of the National Physicians Committee, your committee found, on the part of many, considerable haziness as to what it really was. Among those who were familiar with the organization, the general impression was that it was a potent factor in standing between the medical profession and political control. Your committee has learned from fairly satisfactory sources that the National Physicians Committee is held in high disregard by that radical faction favoring socialization of medicine who, because of its (National Physicians Committee) peculiar composition, have found it impervious to the usual mud-slinging technic of assault. In reply to the Rich statement our answer would be that the surveys show a majority favorable to the National Physicians Committee.

2. Concerning "gross inaccuracies and other inappropriate contents in the committee's publications," the worst that can be said is that certain statements and activities might not have been dignified or appropriate had they emanated from a scientific body such as the American Medical Association, but were not unethical or out of line for agents trained in the technic of combating vicious or unfavorable legislation. It is hoped that in the future the National Physicians Committee will profit by past criticism.

3. Pertaining to financial transactions of unsavory character, no evidence was found to indicate the use of National Physicians Committee founds in bribery or in any unethical manner.

4. A survey of the public relations program of the American Medical Association indicates some substantial progress and the development of far-reaching plans for the future.

(a) The A. M. A. news release mailed weekly to publications and the Associated Press has a mailing list which has reached 2,000. Steadily growing use of this news release by newspapers and magazines has been the cause of considerable satisfaction. It must, however, be kept in mind that the subject matter of this publication is largely scientific and historical.

(*b*) As far as your committee has been able to determine, no effort has been made by the public relations division to establish relations with labor, management, industry, or legislators.

No matter how aggressively the existing and currently proposed measures are implemented, it will take many years before America will have learned to place, with confidence, medical and medical economic leadership in the hands of the American Medical Association. With the greatest possible development along the lines proposed at present, it is doubtful that the American Medical Association will be able to meet effectively or promptly assaults by the enemies of the American way of life—such as exemplified in the recent activity of the National Physicians Committee in blocking what seemed to be certain adoption of compulsory health insurance in Hawaii. In view of the probable admission of Hawaii into statehood, this presented a serious threat of major proportions.

Unquestionably, prompt action by the National Physicians Committee in stimulating and organizing a discouraged profession and in arousing the allied professions, management, industry, and the liberty-loving public in Hawaii to awareness of the grave dangers of such legislation succeeded in defeating this most recent effort of our enemies.

5. The Bureau of Medical Economic Research, under the able leadership of Dr. Frank G. Dickinson, has undertaken or is planning to undertake many important studies in this relatively virgin field. Its activity will be confined to fact-finding. In the near future its findings will be of great value in extending our public relations program.

The conclusions of your committee were as follows:

1. Accusations of financial transactions of "unsavory character" have not been substantiated by fact.
2. With regard to the question of interlocking trusteeship, your committee has, in its December report, expressed its views: "This committee recognized that each member of the American Medical Association is primarily a citizen with the inalienable right to join any organization." As a result of its recent study the committee reiterates this statement.
3. In view of the presently incomplete development of the public relations program of the American Medical Association, there is still a very definite need for continuation of the National Physicians Committee and other organizations established for similar purpose.
4. Even with a fully developed public relations program by the American Medical Association, along lines as presently planned, there will, in all probability, still be a place for the National Physicians Committee for many years to come.
5. Your committee recommends that the house of delegates of the American Medical Association repeat its commendation of two previous occasions on the accomplishments of the National Physicians Committee and resolve a vote of confidence in the managing board of that organization.
6. Last December this committee recommended to the house of delegates that "in line with the new program in the process of accomplishment this committee feels that the American Medical Association should and must do its own public relations and legislative work." It reiterates that recommendation at this time and further recommends appropriation of adequate funds for implementation of a definite program under the guidance of a public relations consultant who will work harmoniously with all American medical agencies.
7. To accomplish this last recommendation, your committee further recommends that adequate changes be made in the public relations department.

William Bates, *Chairman.*
Allen H. Bunce,
Edward H. Cary.
Barney J. Hein.
Thomas K. Lewis.
Samuel J. McClendon.
David D. Scannell.

Public Affairs Institute,
Washington 3, D. C., June 8, 1848.

Hon. H. Alexander Smith,
Subcommittee on Health,
Senate Labor and Public Welfare Committee.

Dear Senator Smith: My attention has been called to testimony given by Marjorie Shearon before your Subcommittee on Health, on Tuesday, June 1, 1948, appearing between pages 1077 and 1090 of the official transcript of the hearing. There, certain mention was made of the Public Affairs Institute containing errors of fact from which erroneous conclusions and inferences were drawn. I am sure you will want to correct these by insertion of this statement in the record, to be printed with appropriate reference to the location of the incorrect testimony given by the witness, so that readers of the record may have the facts straight.

Before taking up specific points made by your witness, may I make a brief statement concerning the Public Affairs Institute. It was organized in October 1947 as an entirely nonpartisan, scientific research institute whose 20 sponsors include some of our Nation's most eminent men. It is a nonprofit organization.

The staff of the Public Affairs Institute includes men of outstanding professional reputations and broad experience, whose published works are standard in their several fields. Among the senior professional men are the following: Dewey Anderson (A. B., M. A., Ph. D.) ; Stephen Raushenbush (A. B. and graduate work), both of whose biographies are found in the current Who's Who ; Herman Lazarus (LL. B. and LL. M.). former legal adviser to member of the National Labor Relations Board ; George H. Morse, former senior engineer of the Federal Power Commission and former dean of engineering, University of Nebraska, whose biography appears in Who's Who in Engineering ; and John G. Shott (A. B. and M. A.), former senior economist of the War Production Board.

The donors and sponsors of the Public Affairs Institute represent no one group. Funds for its support come from an ever-widening circle which now includes 14 different donors. The sponsors are as follows : A. F. Whitney, president, Brotherhood of Railroad Trainmen ; Morris L. Cooke, management engineer, first administrator of REA ; Morris L. Ernst, attorney, author, New York City ; John M. Carmody, former United States Public Works Commissioner ; Theodore J. Kreps, professor of business economics, Stanford University ; James G. Patton, president, National Farmers Union ; Abe Fortas, attorney, former Under Secretary of Interior ; Dr. Alvin Johnson. president emeritus, New School for Social Research, New York City ; John Franklin Carter, columnist, Washington, D. C. ; Fowler Harper, professor of law, Yale University, former Solicitor, Departmenet of Interior ; Morris S. Rosenthal, president, Stein, Hall & Co., Inc., New York City ; Hubert Humphrey, mayor of Minneapolis, Minn. ; Thurman Arnold, attorney, former Assistant Attorney General in charge of Antitrust Division ; Chester Bowles, former OPA Administrator ; J. Frank Burke, president, Standard Broadcasting Co., Los Angeles, Calif. ; Hugh B. Mitchell, former United States Senator from Washington ; Bryn J. Hovde, president, New School for Social Research, New York City ; Harry W. Schacter, president, Kaufman Straus Co., Louisville, Ky. ; Dr. Paul S. Taylor, professor of economics, Berkeley Calif. ; Cass Canfield, chairman of the board, Harper & Bros., publishers ; and Jerome I. Udell, president. Max Udell Sons & Co., New York City.

I am appending for your information one of our published reports, America's Great Hope : Recovery in Europe, as a sample of the kind and quality of research which is done by the Public Affairs Institute. The merit, impartiality, and constructive scientific treatment accorded this timely topic in the report have been widely acclaimed. This is the standard of professional performance which we aim to maintain.

As with other research organizations such as the Brookings Institution, we are asked from time to time to make scientific studies and supply facts to committees of the Congress. This is what happened in the instance which your witness cited when referring to the statement of Senator Joe Ball. There we were asked to supply the minority members, Senators James Murray and Claude Pepper and Representatives John Lesinski and Augustine B. Kelley, with research materials covering the operations of the Taft-Hartley Act.

On page 1079 of your subcommittee transcript. the witness says, "Now, Whitney [A. F. Whitney, president of the Brotherhood of Railroad Trainmen] is the man who is back of this Public Affairs Institute * * * he was the one who initiated this institute for the railroad brotherhood so they would have a particular purpose. It was not a general research organization like the Brookings Institute, but was set up to serve the brotherhood." In reply to the above statements of the witness let me inform you that while A. F. Whitney is a principal sponsor of the Public Affairs Institute, he is associated with some 20 other outstanding Americans from many walk of life who have joined in sponsoring the institute. As I stated earlier, the institute is a research organization of broad purpose devoted to the public interest and dedicated to the strengthening of our free competitive enterprise economy.

Your witness goes on to say. "The significant things in that second article are some of the persons who are on the staff, namely Charles Kramer, who was the staff director of the Pepper Subcommittee on Health and Education" (p. 1080 of the transcript). There follow some pages of discussion of the activities of said Charles Kramer, and then the witness says (p. 1089 of the transcript): "I refer to all this older history because at that time the man who was managing affairs for the committee was this same Charles Kramer, to whom Senator Ball has taken exception, and whom I might say possibly would be the one who would write up the analysis of the report" (an analysis of the Brookings report which Senators Murray and Pepper had informed the subcommittee they had asked the Public Affairs Institute to make).

Senator Donnell then asked the witness this question: "You mean he [Charles Kramer] would write it up for the Public Affairs Institute?" To which your witness replied, "Yes, that is right."

Your witness is entirely in error as to her facts concerning Charles Kramer's relations with the Public Affairs Institute. They have never been related in any way. He has never been an employee of the Public Affairs Institute. To the best of my knowledge, he has never been on the premises of the institute. He has never had any working relationship with the institute, either voluntary or for remuneration. Consequently, to blandly declare that he is the one who would write up whatever analysis we might make of the Brookings report is to handle the truth most carelessly, to say the least. Such loose testimony of the witness should sound a warning of her credibility, for it is not in the public interest that anyone be allowed to make rash and false statements which are calculated to have people believe things that are not true.

Respectfully submitted.

Dewey Anderson,
Executive Director, Public Affairs Institute.

New York 28, N. Y., *June 24, 1948.*

Senator H. Alexander Smith,
Senate Office Building, Washington, D. C.

Dear Senator Smith: In view of the very nasty attacks made on me and on the Physicians' Forum by Mrs. Margery Shearon in the recent hearings of your subcommittee, I am taking the liberty of enclosing a copy of a letter which I have just sent to the New York Herald Tribune and the Washington Post and which I hope will be published. I would appreciate it if you would have this statement included in the proceedings of your committee, in part as a reply to Mrs. Shearon.

For you personal information, since you do not know me, I will add that I myself have never had any direct or indirect affiliations with the Communist Party and have no sympathy with its techniques or its ultimate goals.

Sincerely yours,

Ernst P. Boas, M. D.

New York 28, N. Y., *June 24, 1948.*

In politics it is perhaps not very surprising that defamation of character should have become a more or less normal weapon of debate. But when this and other bad and thoroughly undemocratic practices are used within fields where scientific judgment alone must prevail it is surely time to protest.

In my own field, that of medicine, these tendencies are all too evident. Some 8 years ago a group of New York physicians joined forces to study means for improving medical care and to battle the intransient policies of the local county medical society. Problems of hospitals, clinics, medical education, discrimination were discussed at meetings, and some forward-looking resolutions were introduced in the county society. The organization quickly attracted members from the medical profession all over the country and became the Physicians Forum—a national organization of physicians interested only in the improvement of medical care. After prolonged study its membership reached the mature conclusion that the full benefits of modern medicine can be brought to all the people only through the agency of national compulsory health insurance. They therefore supported the Wagner-Murray-Dingell bill and spoke at Senate committee hearings in its behalf.

This immediately brought on the organization the violent disapproval of the American Medical Association, and of its propaganda satellite, the National Physicians' Committee. The American Medical Association has a vested interest in medical practice as it is. For years it has opposed any and all attempts to make it easier for the patient to pay his medical bills. It fought workmen's compensation insurance, Blue Cross hospital insurance, and voluntary sickness insurance until public opinion forced it to accept these social devices to make medical care more widely available. Today the American Medical Association advocates voluntary health insurance, but only in plans that are wholly controlled by the medical profession, and in the management of which the consumer of medical care has no voice. It is still unalterably opposed to compulsory health insurance, and fights it with every weapon, fair or foul.

For example, in editorials in the Journal of the American Medical Association it has been insinuated that the Physicians Forum is a Communist-front organization; while in the literature distributed by the National Physicians Committee the attack has been more direct. It is stated that compulsory health insurance is derived from Moscow, that all who support it are fronting for Communists, and that health-insurance legislation is chiefly intended to serve as a means of introducing totalitarian methods of government into the United States. The facts that President Truman sent a special message to Congress advocating such legislation, that some of our most distinguished legislators are identified with the Wagner-Murray-Dingell bill, that outstanding citizens such as Bernard Baruch, William Green, Philip Murray, and the late Mayor La Guardia have favored national health insurance are deliberately ignored. These men and many others who have dispassionately studied the matter have reached the conclusion that only through such governmental insurance can modern medicine, which, because of its very advances has become overly expensive, be made accessible to all the people.

Because of the nature of the attacks on the forum by organized medicine many physicians who are in sympathy with its purposes are afraid to become members. They fear it may result in loss of membership in their local county society, of their hospital connections, and that it may hinder their advancement. Such fears have been justified in a number of instances.

Recently the New York County chapter of the Physicians Forum sponsored an opposition ticket at the annual election of officers of the Medical Society of the County of New York. In this election campaign baseless slanders were freely used to gather votes for the regular ticket. The false impression was deliberately created that the opposition slate was a Communist ticket. Every attempt was made to capitalize on the fears which today grip the medical profession no less than the public at large.

Compulsory health insurance has nothing to do with communism nor with Russia. The Physicians Forum has no ideology save the traditional idealism of medicine and the hope of improving medical care in the United States. It has no direct or indirect affiliation with any other organization of any sort. Very definitely it is not a political organization.

I have kept silent a long time, but my patience is running out. We must all learn that this dishonest distortion of the truth is part of a designed movement to suppress freedom of thought and speech, and to stifle new ideas. The attack on me is employed to discredit the Physicians Forum, and the attack on the forum is but an effort to give bad odor to governmental health insurance, and to maintain in power those physicians and groups who seek to preserve the status quo.

Other individuals and other organizations are subjected to similar pressures. If this establishes itself as a pattern of suppression of all novel and unpopular ideas, it will lead to the destruction of political democracy in the United States.

Sincerely yours,

ERNST P. BOAS, M. D.

JUNE 16, 1948.

Hon. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health,
Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: I have read a transcript of the testimony given before your subcommittee by Marjorie Shearon on May 25, 26, 27, 28, and June 1. 1948.

As you know, I am impressed with the importance of the record which has been developed by your subcommittee. I have thought it would be helpful to people using the present hearings, and who do not have easy access to collateral documents relating to Mrs. Shearon's testimony, to have on some of the items in her testimony brief notes which state the facts. Therefore, I have prepared and I am enclosing a memorandum covering such facts.

I respectfully request that you authorize the insertion of this letter and the accompanying memorandum into the hearings, if possible to follow directly after Mrs. Shearon's testimony.

With my respects, I am

Sincerely yours,

I. S. Falk, *Director.*

COMMENTS ON MARJORIE SHEARON'S TESTIMONY OF MAY 25, 26, 27, 28, AND JUNE 1, 1948, SUBMITTED WITH A LETTER OF JUNE 16, 1948, BY I. S. FALK, DIRECTOR, BUREAU OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, FEDERAL SECURITY AGENCY

1. *General note.*—Mrs. Shearon devoted a large part of her testimony to a repetition of items which have already been considered extensively by this committee (Subcommittee on Health, Senate Committee on Labor and Public Welfare) and by other committees of Congress. Anyone reading her present testimony should have ready reference to these other sources of information. In addition to testimony given by me and by Mr. Wilbur J. Cohen, Assistant Director of the Bureau, in these hearings (see pt. 4, July 23, 1947, and January 27 and 29, 1948), the reader should know that many of Mrs. Shearon's charges, criticisms, and attacks, and those of Congressman Harness, were considered at length by the Subcommittee on Labor Department and Federal Security Appropriations (Congressman Keefe, chairman), House Committee on Appropriations. The record appears in the hearings of the Subcommittee on the Supplemental Federal Security Agency Appropriation Bill for 1949 (80th Cong., 2d sess., pp. 514–564). That record is particularly significant with respect to Congressman Harness' charges, the report of his Subcommittee on Publicity and Propaganda in the Executive Departments, their alleged findings concerning the missions to New Zealand and to Japan, his letter to Chairman Taber of the House Appropriations Committee, the case of Mr. Jacob Fisher, and various related matters. It is significant that the House Appropriations Committee dismissed those charges and attacks and made only commendatory comments concerning the work of the Bureau of Research and Statistics in the report which it filed on the appropriation bill H. R. 6355 (H. Rep. No. 1821, 80th Cong., 2d sess., Apr. 27, 1948, pp. 25–26).

It is even more significant that the Senate Committee on Appropriations subsequently increased the appropriation recommended for the Bureau of Research and Statistics after hearing testimony from Mrs. Shearon in which she made many of the same charges, criticisms, and attacks contained in her present testimony. The interested reader should consult the Hearings before the Subcommittee of the Committee on Appropriations on H. R. 6355, United States Senate, Eightieth Congress, second session. Mrs. Shearon's testimony appears on pages 172–192. Replies to her testimony appear in the same volume, as follows: By Mr. J. Donald Kingsley, Assistant Federal Security Administrator, pages 245–266; by Mr. Arthur J. Altmeyer, Commissioners for Social Security, and by me, on pages 266–284. The reader should also consult the report filed for the Senate Committee on Appropriations on H. R. 6355 by Chairman Knowland of the subcommittee (Rept. No. 144, 80th Cong., 2d sess., June 2, 1948, p. 12).

2. *National Health Assembly.*—Concerning Mrs. Shearon's testimony of May 25, 1948, on this subject, see the testimony by Mr. Kingsley (reference in item 1, above).

3. *Costs of health services.*—Concerning Mrs. Shearon's testimony of May 26, 1948, in which she alleged I had stated that "the health insurance program would probably cost 10 percent of pay rolls," what I actually said was as follows:

"Before the war, total expenditures for medical services were about $4,000,000,000 a year (exclusive of the cost of medical care for the armed forces). About three-fourths of this total was spent by patients and their families—the direct consumers of medical care. Four to five percent was contributed by industry and philanthropy. The remaining 20 percent was spent by Federal, State, and local governments."

* * * * * * *

"The prewar level of expenditures for medical services, public and private, may not, however, have been fully adequate to pay the cost of services equal to our modern needs and standards. In the years ahead, especially if our economy operates with stability and at a high level of employment, our total expenditures for health and medical services might advantageously be expanded from the $4,000,000,000 of prewar years to as much as five, six, or even nearly seven billion dollars a year under arrangements that will make adequate services and care available to the entire population. Those larger amounts for the future might be only 6 percent of national income. This should be compared with the 5 percent of national income (a total of about $3,000,000,000) expended about 10 years ago in times of deep economic depression when the degrees of economic freedom and the margins of flexibility in our expenditure patterns were very low indeed. These and all such figures should be measured against the $10,000,000,000 commonly accepted as a conservative estimate of the direct and indirect annual costs of sickness and disability." (From a paper on Unmet Health Needs, presented before the American Public Health Association, Oct. 4, 1944, American Journal of Public Health, 1944, 34, p. 1229.)

Mrs. Shearon says I then went on in that paper to discuss the costs of cash sickness and disability benefits. If the reader will consult the article in question, he will find there was no such discussion there. Our cost estimates for disability insurance (temporary or permanent) do appear in various public documents, but they do not support the incorrect total cited by Mrs. Shearon.

4. *The Friedman testimony on our statistics.*—The reader is invited to consult the comments on that testimony furnished by the Federal Security Agency, appearing in these hearings, part 2, pages 686–723.

5. *Days of illness under health insurance.*—In her testimony of May 26, 1948, Mrs. Shearon repeats the well-known misinformation about increase in days of illness under health insurance in other countries. Neither Mrs. Shearon nor others whom she has cited as her authority had any statistics that reliably measure days of illness among the insured persons. They had figures on days of incapacity compensated because of wage loss. Anyone familiar with statistics of this kind knows that in cash sickness insurance the number of compensable days per insured worker increases when the insurance specifications are liberalized, and that unless changes in the benefit specifications are taken into account, the data cannot be used to indicate trends in the real amount of illness or incapacity among the insured persons. On this point, the interested reader might consult my discussion of this subject in Security Against Sickness, 1936, pages 107–117, a volume from which Mrs. Shearon has frequently quoted.

6. *Mr. Jacob Fisher.*—In her testimony of May 27, 1948, Mrs. Shearon revived the charges made by Congressman Harness against Mr. Jacob Fisher, though by this time it was a matter of public record that he had been exonerated of those charges. An investigation of Mr. Fisher's loyalty was made by the FBI. The Board of Inquiry on Employee Loyalty, Federal Security Agency, which had the results of the FBI investigation, reported on March 24, 1948, that the evidence received by it does not warrant the filing of charges of disloyalty against Mr. Fisher, that it had recommended to the Federal Security Administrator that the case be closed, and that the Administrator has approved the recommendation and closed the case.

For a fuller account of this case, the charges made without hearing, and the results, see pages 532–535 of the House Appropriations Committee hearings cited in item 1 above.

7. *Senate Advisory Council report and Mr. George W. K. Grange.*—In her testimony of June 1, 1948, Mrs. Shearon confirms her previously expressed objections against the actuarial work done by Mr. George W. K. Grange of the Metropolitan Life Insurance Co. in reviewing estimates developed by the Social Security Administration's actuary for the 1948 Advisory Council on Social Security, Senate Committee on Finance. Mrs. Shearon said (transcript, p. 1053): "I have since learned that he (Mr. Grange) was formerly with the Social Security Board also, so the tie-in there, as I said, was very, very strong * * *."

According to the official records, Mr. Grange was employed by the Social Security Board as a temporary actuarial mathematician for 3 days in 1937 and for 8 days in 1938.

8. *Capitation payments and per capita costs.*—In her testimony of June 1, 1948, Mrs. Shearon repeats her argument that I advocated the capitation method of paying doctors under health insurance. She buttresses her argument first by excerpting from their context part of one sentence from one paragraph and all of one sentence from another paragraph in an article of mine published in the New England Journal of Medicine (230: 1944, pp. 243–249). The reader will be able to see how she misrepresented my views by reading the whole of the two paragraphs from which those sentences (emphasized here) were taken:

"*There is little doubt that some of the most serious deficiencies of present-day medical practice result from the fee-for-service method of payment*, because it discourages early, preventive, or adequate care—especially among people of modest means—at the same time that it puts a premium on excessive treatment in some cases and inadequate treatment in others, and on various types of fee-splitting practices. Some of these objectionable features would be carried over into the insurance system, despite precautions that might be taken. Although the patient would no longer be barred from needed services, there would be a risk that some physicians would load unwarranted service charges on the insurance fund. Since the aggregate amounts available for all payments to physicians would be limited, the result might be a competition for patients and for volume of services almost as inimical to professional standards as that which occurs today. Through the downward prorating of physicians' bills if they are excessive, the insurance fund can be protected against extreme unwarranted costs. For the rest, the problem would be largely a matter of intraprofessional controls.

"*Practitioners here, like those in Great Britain, would probably turn to a capitation or a salary basis of payment, because they would learn by experience that these methods are more satisfactory for them as well as for their patients.* Nevertheless, I do not agree that the insurance system should bar the fee-for-service method. So long as a majority of physicians prefer or insist on a fee basis, it should be accepted by the social-insurance system. At the same time, it should give full opportunity for the development of organized group practice where this arrangement is preferred by physicians and insured persons. In other words, the insurance system should build on what now exists, and at the same time should build toward better arrangements by leaving latitude for change and improvement as rapidly as change is desired by or is acceptable to those who are most concerned."

Then Mrs. Shearon cites, as further evidence that I advocated the capitation method of payment, the fact that I repeatedly used per capita costs in the volume on Medical Care Insurance which we furnished the Senate Committee on Education and Labor and which they printed as their Committee Print No. 5, July 8, 1946. This citation by Mrs. Shearon evidences utter confusion or misrepresentation. Anyone who consults that volume will find that the term per capita costs and dollars expressed as per capita costs merely give the costs divided by population, and that such per capita costs have no bearing upon, or relation to, the method of paying for services.

9. *Ultimate objectives.*—In her testimony of June 1, 1948, Mrs. Shearon alleges that we "have in mind as an ultimate objective * * * a complete national medical service, a salaried service, such as they have in Russia" (transcript, p. 1124). In support of this she quotes excerpts from the Provisional Record of the Social Security Consultation on Income Maintenance and Medical Care, called by the ILO in Montreal, July 9–12, 1943.

Her discussion of this subject is confused and her quoted excerpts are misrepresentations. The plain facts are that the conference was discussing, and suggesting revisions in, a draft document which had been prepared by the ILO staff to indicate elements which should be weighed by any country when considering one method or another for dealing with its medical-care problem. Mrs. Shearon quoted from the Provisional Record only the introductory lines of paragraph 403 in the revised ILO document. The true meaning of those lines, and Mrs. Shearon's misuse of them, are evident when they are seen in their original setting. Following is the complete text of paragraph 403 from which she excerpted, and also the complete text of the companion paragraph (par. 405) which immediately followed and from which she did not quote (emphasized in the original):

"403. Indications for medical care through public services. *Such services may be preferred, especially as an ultimate objective, in the light of experience accumulated under contributory social insurance:*

"(a) *because all prospective beneficiaries have same title to benefits;*

"(b) *because provision for essential need should not depend on any qualifying conditions;*

"(c) *when it is desirable to integrate medical care services with other health services.*

"405. Indications for medical care through social insurance services. *Such services may be preferred:*

"(a) *where services are limited to a section of the population or to a specified area;*

"(b) *when wholly or principally financed by contributions, with or without partial financing from general tax funds;*

"(c) *where the contributory mechanism already exists for other classes of social insurances.*

From this, and similar ILO material, Mrs. Shearon concocts an international plot and program. For further analysis on this subject, see these hearings, part

4, pages 1729–1739, and 1780–1786, for my notes on her Blueprint and on the anonymous article which Mrs. Shearon said had been prepared by Miss Hazel Huffman and which was published in Medical Economics, November 1945.

10. *United States membership in ILO.*—Concerning Mrs. Shearon's garbled account of this subject in her testimony of June 1, 1948, see my notes on this subject in commenting on her Blueprint (in these hearings, Pt. 4, pp. 1729–1739).

11. *Authority to study health insurance.*—In her testimony of June 1, 1948, Mrs. Shearon gives her account of the history of section 702 of the Social Security Act, and alleges Congress did not want the Social Security Board to study health insurance. All of this is her own invention. For the facts in the case, see Mr. Altmeyer's testimony before the Senate Appropriations Committee, cited in item 1, above.

12. *Mrs. Shearon's views in 1939.*—Concerning Mrs. Shearon's views at the time Senator Wagner's 1939 health bill was being developed (her testimony of June 1, 1948), see documents prepared by her and introduced in these hearings by Senator Pepper (pt. 4, pp. 1800–1820). It will be plain that, at that time, she was intemperately critical of the proposals being considered because they did not go far enough in covering population groups through compulsory health insurance and because they exposed otherwise self-supporting people to a means test in order to obtain medical care.

13. *History of the Wagner-Murray-Dingell bill.*—For comments on Mrs. Shearon's testimony on this subject, see my testimony of July 23, 1947, and January 27, 1948 (these hearings, pt. 4), and my notes on her Blueprint, pages 1729–1739.

14. *Article in Administrative Medicine.*—Mrs. Shearon's account (her testimony of June 1, 1948) of the writing of an article for this volume and the handling of an honorarium for it is basically false, since I never asked her or any other member of our staff to work on Government time for outside pay. It is significant that she did not make these charges about receiving outside pay for work on Government time to the competent administrative officers of the Social Security Board at the time, and that she comes up with them only now, nearly 10 years after the alleged event.

The record shows that in January 1942, directly after the volume containing the article was published, I wrote to the publisher as follows (emphasis added here):

"May I suggest a particular method of handling the honorarium which was originally offered for the article? When the job of preparing it was first undertaken, Mrs. Marjorie Shearon undertook to collaborate with me and it was our agreement that she was to receive one-half of the honorarium mentioned in the first letter from Dr. Emerson. Later, when she left the staff of this Bureau, and could not participate in the further revision of the document, she asked to withdraw from the project and requested that her name be dropped from the joint authorship which the manuscript carried. Inasmuch as she did all of the work which her original commitment required of her when the invitation from Dr. Emerson was accepted, I believe she is entitled to receive so much of the honorarium as was first intended for her, *particularly because it is my recollection that she did her work on this job out of office hours and in her leisure time.* I would, therefore, suggest that a check in the amount of one-half of the honorarium be sent directly to her at the following address: Post Office Box 4034, Chevy Chase, Md."

(Subsequently Dr. Shearon submitted a final statement in reply to Dr. Falk as follows:)

FINAL STATEMENT BY MARJORIE SHEARON, PH. D. IN REPLY TO COMMENTS BY I. S. FALK ON HER TESTIMONY

Without prolonging this discussion unduly, I shall avail myself of the opportunity offered to me by the Health Subcommittee of the Senate Committee on Labor and Public Welfare to reply to comments on my testimony.

When we view these five volumes of testimony which have been presented in connection with S. 545 and S. 1320, a few facts stand out with crystal clearness. I made a series of charges regarding the activities of Federal officials in promoting legislation for the establishment of state socialism in the United States. My charges have been substantiated by admissions which those officials have made under cross-examination and by admissions of other witnesses. Mr. Falk has been verbose and has attempted to confuse issues, but the following facts may be gleaned from the record:

1. Agitation for enactment of national compulsory "health" (i. e., sickness) insurance as part of a comprehensive system of social security covering the entire population, has originated in the Bureau of Research and Statistics of the Social Security Administration in the Federal Security Agency.

2. Isidore Sydney Falk, director of the above-mentioned Bureau of Research and Statistics, has been mainly responsible for the drafting of successive bills in the Wagner-Murray-Dingell series and of the initial 1939 health bill introduced by Senator Wagner.

3. Falk has planned and directed the propaganda campaign for the gradual nationalization of medicine, and in so doing has broken a Federal law (title 18, sec. 201, USC).

4. Falk has worked cooperatively with the two nongovernmental lobbying organizations which are working for the nationalization of medicine by enactment of Federal compulsory sickness insurance legislation. These two organizations are the Committee for the Nation's Health, Inc., and the Physicians Forum, Inc.

5. The organizer and de facto leader of the Committee for the Nation's Health, Inc., is Michael M. Davis, who has been associated with Falk for 20 years. The leader of the Physicians Forum, Inc., is P. Boas, M. D. Both organizations have collaborated with the International Workers Order, a Communist organization. Dr. Boas is, or has been, a member of eight Communist-front organizations.

6. Dr. Maurice Friedman, a practicing physician in Washington, D. C., demonstrated with scientific accuracy in his two appearances before the Health Subcommittee that many of the statistics and interpretations which have emanated from the Bureau of Research and Statistics during more than a decade have been false and misleading. It is futile for Falk in paragraph 4 of his statement to refer the reader to the reply to Dr. Friedman's assertions which were introduced into the record by the Federal Security Agency. Dr. Friedman's rebuttal to that weak attempt to defend Falk constitutes an even stronger indictment of the Bureau of Research and Statistics and its director than did Dr. Freidman's original testimony.

7. In paragraph 6 of his statement Falk once again rises to the defense of Jacob Fisher, a member of his staff who was denounced by Congressman Harness for un-American activities. Fisher was later investigated by the Employee Loyalty Board of the Federal Security Agency and was exonerated. Oscar Ewing concurred in giving Jacob Fisher his official blessing insofar as loyalty was concerned. However, there will be plenty of Americans who will not relish the Fisher, Falk, and Ewing brand of loyalty. The House Committee on Un-American Activities gives the following information about Jacob Fisher in its six volume report published in 1944.

(*a*) Fisher was a sponsor of a conference called by the Consumers National Federation, an organization described by Earl Browder (Communist) as a transmission belt. A transmission belt, in Communist nomenclature, is an organization through which the Communist Party extends its influence and ideology to groups which are broader than the party itself.

(*b*) In 1939 Fisher sponsored a campaign launched by the Friends of the Abraham Lincoln Brigade, an organization which was controlled by the Communist Party. Also associated with the brigade were Ernst P. Boas, M. D., the Communist, Langston Hughes, and several members of the National Citizens Political Action Committee.

(*c*) During the 1930's Fisher was active in the Interprofessional Association for Social Insurance, as well as its secretary, and was a member of its executive committee. In that organization he was associated with numerous Communists and members of Communist-front organizations. (See pp. 915–922 of the House Report on Communist-Front Organizations for a discussion of the activties of the Interprofessional Association for Social Insurance.) The objectives of professional workers who have banded together to aid in the revolution in the United States are discussed in a pamphlet entitled "Professionals in a Soviet America." In this document the author, Edward Magnus, states:

"*The Way Out: United Revolutionary Action.*—Although the professionals cannot be the leaders in the struggle for a new society, there are many ways in which they can improve their immediate position, and help bring about the new society, by following the lead of the workers and fighting together with them * * *.

"For the professional who has realized this, there already exist many ways in which he can join in the fight for these immediate objectives, and for the final victory of the working class in its struggle against capitalism * * *.

"Through the Interprofessional Association for Social Insurance, all professionals can join with labor for real social insurance * * *.

"Everywhere the professional who engages in these activities will feel the directing power of the Communist Party, the revolutionary party of the working class."

Fisher was a member of the National Executive Committee of the Interprofessional Association which actively supported the Lundeen social insurance bill in 1935. Others supporting that bill were the Communists Israel Amter, Earl Browder, and Max Bedacht, general secretary of the International Workers Order, for which in more recent years Falk's assaciate, Michael M. Davis, prepared a film script in support of compulsory health insuranoce.

Fisher is the man whom Falk has retained in the Bureau of Research and Statistics. Fisher is the man who was willing to act as a tool in preparing a phony report on medical care in New Zealand which was to be introduced at the Senate hearings in the name of W. B. Sutch of New Zealand. (See these hearings.) Fisher is the man Falk was about to send to New Zealand to make a study of social insurance. Congressman Harness blocked that move. Fisher still remains on Falk's staff. He is defended by Falk and backed by Oscar Ewing. He has associated with and worked with Communists and Communist organizations. Every decent, loyal American has a right to question the loyalty of Fisher and to ask why he is being employed at the taxpayer's expense to foist an alien program of social security on the United States.

8. In paragraph 8 of his statement Falk comments on capitation payments and per capita costs. When I testified at these hearings I made the point that Falk favored the capitation or salary method of payment for physicians and dentists and that in his own printed statement on medical-care insurance he repeatedly showed a preference for the capitation method. As a matter of fact, the leading protagonists of national compulsory health insurance, Falk included, have all condemned the fee-for-service method of payment and have favored either capitation or salary. My reason for pointing out this fact was that adoption of either the capitation or salary method of payment, especially if the entire working population and all dependents are brought into the social-security system, would result in a complete reorganization of medical practice and in political control thereof.

Falk claimed that I misrepresented his views. He claimed that I excerpted sentences from their context. He failed to state that Senator Donnell quoted entire passages and after doing so stated that he came to exactly the same conclusions about Falk's preference for capitation that I had come to. (See testimony.)

Falk claimed I misunderstood his methods of computing physicians' income. The trouble with Falk was that I understood him all too well and that he objected to my pointing out what he was trying to do to this country. On page 45 of his report on medical care insurance he states specifically:

"The expected costs of general practitioner services for the insured population are usually computed on a capitation basis (as will be done in ch. VI). The same amounts may be used as the financial basis for each method of remuneration which local groups of physicians may choose from among the alternatives open to them."

In other words, the amount of money that will be made available to the practitioners of the country will be computed on a capitation basis. Federal officials will decide whether practitioners are to receive $5, $6, or $7 a year per person on their lists. The amount will be multiplied by the population being served, say, 143,000,000 persons. That's all the money there will be to pay the general practitioners of the country. They may take it on a capitation basis, or on a salary, or possibly on a fee-for-service basis but they will not get any more. The main idea is to level downward, insofar as rewards for service are concerned. Falk states regarding the capitation method: "As in the case of payment per service, all general practitioners in the area are paid at the same rate (a uniform per capita amount)." He further explains that if there are 1,500 persons on a physician's panel at $7.50 per head per year, the capitation amount for the year would be $11,250. The physician might take that amount on a salary basis or make his fee scale so low that his total income would not exceed $11,250 gross. But in any event, whatever that total gross income turned out to be, when figured on a capitation basis, that is the amount a physician would receive on the average. The number of persons permissible on a physician's list is more frequently specified by Falk as 1,250. If the Government decided it could afford only $5 or $6 per capita, the gross income per physician would be $6,250 or $7,500. I reiterate, then, that Falk plans in terms of a capitation system at the start and would wind up with a salary system which is the only way that is feasible if Government does the job. Administratively and financially, nothing approaches the salary system when it comes to controlling a Government medical service and expenditures therefor.

9. Reference may be made to paragraph 10 of Falk's statement and to his notes in volume IV. Without going into a detailed answer to all of Falk's comments about my Blueprint for the Nationalization of Medicine and the ILO, I may say that of course this country has had part of the program of state socialism since it introduced workmen's compensation, passed the Federal income-tax law—one of the most dangerous on the books—and enacted the Social Security Act in 1935. We have been moving fairly steadily to the left until now we have a labor government under President Truman. We are now facing squarely the issue of whether or not to accept the rest of state socialism. One has only to look back a dozen years to see how far left this country has moved in the field of social security and to see, further, the great impetus that has been given to the movement to enact a Federal law for the nationalization of medicine. This movement has been spearheaded by Falk since he entered the Government in 1936. He has spent over $3,000,000 of the taxpayers' money to foist this program on the American people. He has written some 60 papers and speeches, while in the Federal service, in favor of compulsory sickness insurance or on related subjects. He has derived his chief support from A. J. Altmeyer, Commissioner for Social Security. Working quietly behind the scenes, he has indoctrinated successive Federal Security Administrators, Members of Congress, and even the President of the United States to the point where they believe that national compulsory sickness insurance is desirable for this country. Until 1947 when, at my urging, he was requested to appear before the Health Subcommittee of the Senate Committee on Labor and Public Welfare, he had not testified in favor of the compulsory sickness insurance bills which he had written. Instead, he worked through others, using as sounding boards Commissioner Altmeyer, Senators Wagner and Murray, the CIO and AFL, and, more recently, Oscar R. Ewing.

10. In paragraph 12 of Falk's statement reference is made to my views in 1938 regarding national compulsory health insurance. Several memoranda of mine are quoted along with drafts of the bill which, in a revised form, was introduced by Senator Wagner as the 1939 health bill. I had been on Falk's staff for about a year at the time I wrote those memoranda. He had asked me to prepare a draft bill that would carry out recommendation III of the 1938 national health conference. Miss Margaret Klem was asked to draft another bill to carry out recommendation IV. When the two drafts were completed I was asked to splice them. The result was an absurd draft bill. It left my hands in November 1938 and I did not see it again until Senator Wagner introduced a modified version in 1939 (S. 1620, 74th Cong.).

More important than the provisions of those drafts is the fact that here is clear and incontestable proof that the first Wagner health bill of 1939 was drafted by Falk and his staff. The legislative proposal incorporated Falk's ideas. Explanations and supporting data were prepared by his staff. Finishing touches were put on by Falk himself. Indeed, his procedure was to file the research reports prepared by his staff and to prepare his own devious reports based on honestly prepared memoranda. He would twist statements of fact and interpretations until they were wide of the truth. This was what led his staff to distrust his work and his publications.

As to my views on compulsory health insurance in 1938, I have this statement to make: In the first place, I was new to the field as were all other members on Falk's staff. I had been working part time on health insurance for 1 year and had made no study of the administration of such a program. The staff in 1938 was undergoing a regular process of indoctrination as to the need for intervention by the Federal Government, the inadequacy of medical care, unmet health needs, and the miraculous results that would be achieved under a program of national compulsory "health" insurance. Falk was generally hailed as an expert in the health field. He himself, in staff meetings, discoursed at length on his own qualifications as an expert and on his vast experience. However, it took only a short time for most members of the staff to see that Falk was not truthful and that he lacked integrity. These staff members found it repugnant to be involved in Falkian plots to deceive other Federal officials, the Members of Congress, and the public. Bit by bit we discovered that Falk's statistics and statements were untrue, "slanted," and generally deceptive. As we spent more time on trying to work out administrative procedures for a national compulsory "health" insurance scheme, we found more and more objections to such a system. I myself was then and still am strongly opposed to the social work means test. I therefore sought some form of legislation that would avoid such a test as a prerequisite for receipt of medical care at public expense. Health insurance obviously was a device that seemed to eliminate the means test. However, such a system was extremely cumbersome with respect to exclusion of persons not entitled to benefits. It made receipt of medical care dependent not on medical needs but on work records. It seemed to me then, and still seems to me, that if the Federal Government is going to do the job of providing medical care for the entire population a public medical care system is the only feasible approach. Indeed, the social insurance approach for total populations is without justification. That is why ultimately a nation which begins with social-insurance medicine is bound to end up with public medical care financed from general revenues and administered almost exclusively as a salaried service.

It took me 7 years to see the whole significance of social-security medicine as planned by Falk. After half that time had elapsed I left his staff. After the full 7 years had passed, I severed connections with the executive branch of the Federal Government because I would have no part in putting over such a thoroughly vicious scheme on the American people. Since 1945 I have been endeavoring to explain to as many people as I could reach the significance of compulsory social-security medicine as part of a comprehensive scheme of national compulsory social security for the entire population. I have described the administrative compulsions and controls which I did not understand in 1938. I have dwelt especially on the huge costs of a Government system of medicine. Advance estimates of cost made by experts always fall short of actual experience. Indeed, were Government experts to tell the truth about the costs, the high taxes, and the administrative complexities, it is doubtful if any country would be willing to jeopardize its financial stability by legislating a system of state socalism based on compulsory social security for the entire population.

I have come to think that public medical care should be limited to that portion of the population that is unable to purchase its own services. I think it is better to have a means test of some sort for a portion of the population, possibly 15 or 20 percent, than to put the entire population in a strait-jacket through compulsory social-security laws. The means test need be no worse than the preparation of an income-tax form; it does not have to be a social work means test. In any event, I believe it is socially more beneficial to the Nation to have a small part of the population suffer to a certain extent under the administration of a public medical care program than it is to debase the medical care of the remaining part of the population by turning all arrangements over to the Government. I now know that there was no validity in the statistics on unmet need which emanated from the Bureau of Research and Statistics of the Social Security Administration. I do not believe that there is grass-roots demand for Government medical care. I know that the demand arose in the minds of I. S. Falk, A. J. Altmeyer, Wilbur J. Cohen, Michael M. Davis, Ernst P. Boas, and a few of their followers. Such being the case, we should reexamine the health needs of the country and should decide whether there is any justification for Federal intervention in the provision of personal health and medical services.

11. I pointed out in my testimony that one member after another on Falk's staff had resigned because of his lack of integrity and that when they resigned they explained with great particularity why they were leaving. He has never seen fit to answer that significant charge except by stating that, of course, he had experienced a turn-over of personnel, just as other administrators had. He has failed to anwser my statement that his senior staff members resigned not for the usual reasons, not to seek more lucrative positions or more interesting ones, but because they distruted Falk and the work that was being done in the Bureau which he headed. They distrusted his methods and his manner of juggling statistics. They resented the way in which he was misleading the public and the Congress of the United States. I submit that he has never explained away the specific charges of malfeasance in public office which were made by myself and by other members of his staff.

12. Falk has broken the Federal law relating to lobbying by Federal employees (title 18, sec. 201, U. S. C.) and he contravened the spirit of the law, if he did not actually break it, when he ordered the editor of Nelson's magazine to send me a check for $50 for work I had done on Government time as an official assignment. The law which Falk was breaking was 5 U. S. C. 66. In paragraph 14 of his statement he says:

"It is significant that she did not make these charges about receiving pay for work on Government time to the competent administrative officers of the Social Security Board at the time, and that she comes up with them now—nearly 10 years after the alleged event."

By saying this, Falk is telling an untruth and he knows that it is an untruth. He is fully aware of the fact that on April 30, 1942, I brought out this entire matter at an appeal hearing before a board headed by a member of the staff of the Civil Service Commission. On that board was a representative of the Social Security Board. Present also was Mrs. Sarah Napier, a member of the staff of Oscar M. Powell, executive director of the Social Security Board at that time. The facts regarding Falk's maladministration were given to this group during a 4-hour presentation of voluminous documentary evidence. No steps were taken against him because he was protected by Arthur J. Altmeyer. At an earlier date, a few days before my transfer from Falk's staff to the Public Health Service was approved on April 15, 1941, I had a long interview with Altmeyer, at that time Chairman of the Social Security Board. I spoke particularly of Falk's lack of integrity and the fact that the staff was requested, nay, ordered to slant research memoranda Falk's way. I asked Altmeyer to investigate the disgraceful conditions obtaining in the Bureau of Research and Statistics. He refused to do so and said that employees should do what their supervisor told them to do. When I reminded him that Falk asked his employees to prepare misleading documents, he still insisted that employees should obey their supervisors.

The entire situation within the Bureau of Research and Statistics was known in detail to members of the staff of Mr. Paul V. McNutt, former Federal Security Administrator. It is known to members of the staff of Oscar R. Ewing, present Administrator.

Falk complains that it has taken me nearly a decade to bring out the facts about his breaking Federal laws. It would be more accurate to say that it has taken a decade for the charges of maladministration to reach the Halls of Congress. With meticulous care the various members of Falk's staff made their charges of maladministration on his part as they resigned from his staff. These charges were made to the Civil Service Commission, to a congressional investigating committee, to all the top administrative officials in the Social Security Board, to Mary Switzer, administrative assistant to the Federal Security Administrator, and to other officials in the top echelon at the Federal Security Agency. Complaints and charges were received with such comments as: "We know about the conditions in that Bureau, but nothing can be done so long as Falk is backed by Altmeyer."

I left Falk's staff on April 15, 1941. Four years later Ruth Stocking, M. D., likewise left his staff and severed connections with the Federal Government. On March 28, 1945, the day Dr. Stocking left the Government service, I wrote to Mary Switzer, administrative assistant to Paul V. McNutt, in part as follows:

"DEAR MARY: At long last Ruth Stocking, M. D., has resigned from Falk's staff. * * * So, one by one, the experts in the field of social insurance are driven out out of a career service in Government because they will not be part of a corrupt regime. Each person in turn has placed the facts before Mr. Powell (executive director of the Social Security Board), personnel officers, and members of the Board, and has, as a final duty, apprised members of Mr. McNutt's staff about Falk's skulduggery. To what end?

"During all these years Falk has wasted the taxpayers' money on sterile projects of little or no value. He has spent well over $3,000,000 for what? He has initiated literally hundreds of worthless studies. When honest members of his staff protested that the projects were boondoggles, Falk crucified them. During this same period there has been public interest in developing a national-health program. Falk has stood squarely in the way of accomplishing anything constructive. Using Federal funds, he has built up a promotional and propaganda organization in the Social Security Board for the express purpose of foisting on the American people a German-made scheme of sickness insurance which he hopes to control. If his plans succeeded, he would have the $3,000,000 annual health kitty to play with. Twice he has been the prime mover in drafting Federal legislation to accomplish these ends; twice Members of Congress have been sold down the river because they believed the cock-and-bull stories Falk told them about sickness insurance.

"Possibly you would counter that the Wagner-Murray-Dingell bill is a dead issue, that even in amended form it would not have a chance. I hope that is true, but I bear in mind that Bismarck put through the original sickness-insurance scheme against great opposition and paved the way for national socialism; that Lloyd George 'pulled a fast one' on the doctors of Great Britain and saddled that country with a compulsory scheme; and that Walter Nash did the same in New

Zealand. And I bear in mind that no country has ever been able to rid itself of this type of compulsory legislation once it was adopted because after taxes have been collected and commitments have been made to the people, it is almost impossible for the Government to extricate itself no matter how great the popular dissatisfaction with the legislation.

"Falk knows these things. But he has lied about the operations of compulsory sickness insurance. He has misled members of the Social Security Board, the Members of Congress, and the public. That is why no honest person will stay with him; that is why a long line of experts have preferred to leave the Government rather than have any part in what he has done.

"I think you will agree that the experts have had patience. Each of us in turn has presented these facts through proper administrative procedures. We have not sought to embarrass the agencies with which we were working. We have not publicized the facts. For over 8 years we have sought by peaceable means to have a rotten spot in the Government cleaned out. Has anything ever been done by anyone to correct any of the abuses in the Bureau of Research and Statistics of the Social Security Board? The Federal Security Agency, fully aware of the conditions in that Bureau, still asks Congress for funds to support a Bureau that has been notoriously engaged in working against the public interest. It is a matter of common knowledge that Falk has padded pay rolls, abused travel authority, appointed staff for personal rather than professional reasons, broken Federal laws, and in general behaved as though he were a law unto himself.

"I have an idea that all those who have connived at what has been going on these many years in the Social Security Board will one day reap an unexpected whirlwind. Neither Altmeyer, nor Bigge, nor Mrs. Woodward, nor Powell, nor the top people in the Federal Security Agency will be able to claim they were in ignorance of what was going on. The successive resignations of each of the experts in turn are a matter of record.

"Sincerely yours,

"MARJORIE SHEARON."

Falk, in paragraph 14 of his statement, says that my account of the writing of the article for Nelson's Administrative Medicine is "basically false, since I never asked her or any other member of our staff to work on Government time for outside pay." This statement by Falk is false. He asked me to prepare the article for him, saying he was too busy. He excused his action by stating that he would not think of asking me to do the work on Government time were it not in line with investigations I would be making anyway. The writing of the article was my major piece of work for about 2 months, and was so recorded on my official reports of activities. I did not at any time agree to accept any money. Falk told me there would be something in it for me, but I did not say I would accept the money. Instead, I went to the personnel office to see how I could get out of such a corrupt bureau. I finally succeeded in 1941. More than a year after I had left the Board, I received a check for $50 from Nelson & Sons. I was about to return it when I was advised to retain it as evidence. I did so. Early in 1945, after I had severed my connections with the Government, I received a letter from Nelson's reminding me that the check was still outstanding. At that time I wrote the following letter to Nelson's:

CHEVY CHASE, MD., *March 15, 1945.*

MR. H. BAGLEY,
Thomas Nelson & Sons, New York, N. Y.

DEAR MR. BAGLEY: In reply to your letter of February 26, 1945, regarding the check for $50, dated October 23, 1942, I may state that I have the check and intend to retain it, but shall not cash it.

I did not at any time authorize Mr. I. S. Falk to have the check sent to me. It is true that he asked me to write the original article for him. I did so unwillingly, but I was on his staff and he assigned the task as an official duty. I did the work on Government time and was paid by the Government. I used Government secretaries and stationery. It is against the law (5 U. S. C. 66) for a Government employee to accept money from any source other than the Government for work done as part of one's official duties.

Shortly before the time Mr. Falk asked me to write the article, I had complained about his corrupt administration. When he asked me to do the writing he stated there would be a little honorarium in it for me that would help me to pay my Christmas bills and that he could throw other little chances my way to make extra money on Government time. I wrote the article, leaving my name off, and simultaneously asked to be transferred out of the Bureau of Research and Statistics, of which Falk was then Assistant Director.

For a variety of reasons the article was delayed in publication. Falk had put his name and mine on the manuscript as joint authors. I decided not to make an issue of the matter until I could get out of his sphere of influence. The manuscript hung fire from late 1938 to early 1941. There was a renewed request to have the material brought up to date. My plans were then nearly complete to get away from Falk, so I wrote him to take my name off the manuscript since I wanted no connection with it. As a matter of fact, were no other consideration involved, I would not have had my name associated with his because of his unsavory reputation. I would not have jeopardized my own professional standing by publishing anything jointly with Falk.

On April 15, 1941, my transfer to another agency became effective. I returned the manuscript to Falk, and so far as I was concerned the incident was closed. A year later, in quite another connection, I mentioned to a certain committee that was looking into Falk's activities the fact that his conduct was improper in that he took the lead in suggesting to his staff that they break the law. Falk then, on April 30, 1942, stated for the first time that he had notified Nelson's to send me a check for $50. The other $50 was to go to Barkev Sanders who had put some finishing, and probably unreliable, touches to the article after I had left. This, mind you, was a year after I had left Falk's staff and had told him to remove my name from the article. Furthermore, as soon as I left the Social Security Board in 1941 I wrote to Dr. Haven Emerson stating that I wanted no connection with the article and that I would not have my name appear either as joint author or in a footnote acknowledgment. Dr. Emerson assured me that he would respect my wishes.

To my great surprise, after all this, I received a check from you in October 1942. I was about to return the check to you, when I was advised to retain it as evidence against Falk. He knew it was against the law to permit his staff members to receive money for work done on Government time. It was even worse for him to take the lead in instructing his staff how to break the law on the sly. The facts, and the check, are in the hands of the proper authorities.

Nelson's, of course, is not involved.

It is an unfortunate thing that so many Government officials have overlooked the fact that a public office is a public trust. Greedy for power and money, they have made a travesty of civil service. I finally resigned from the executive branch of the Government in complete disgust and am now with the Senate Minority Conference as a consultant in health and related matters.

Sincerely yours,

MARJORIE SHEARON.

I have gone into this matter of unlawful conduct on the part of Falk because the day may yet arrive when Congress will make a genuine investigation of his activities. This is a clear case of his breaking a Federal law. There are other illustrations. Falk was investigated by the Ramspeck committee in 1943, and a report on him was prepared. Before action could be taken certain changes in the committee staff were made and prosecution was held up.

13. Out of the voluminous testimony that has been given there emerges one clear picture of what has happened: One Federal official, I. S. Falk, has planned to take over control of American medicine by using the device of a Federal compulsory sickness insurance law, drafts of which he has written and promoted. It has been demonstrated at public hearings that he broke Federal laws, that he has published misleading reports, that he has misrepresented the pattern of administration and the costs of the program which he is seeking to force on the American people. He has lied to committees of Congress, breaking another Federal law in so doing. He has on his staff at least one person who has worked closely with Communists seeking the overthrow of the Government of the United States. He has furnished material to persons following the Communist line, namely Ernst P. Boas, M. D., and Michael M. Davis. The former is or was a member of the Communist-front organizations; the latter prepared material for a Communist organization.

The American people have a right to expect unquestioned loyalty from their Federal officials, and they likewise have a right to expect such officials to obey Federal laws. I. S. Falk has failed in both respects. He has spent millions of dollars of tax funds to promote the nationalization of medicine. He has been responsible for untold indirect losses of time and money because of the months that have been spent by public officials, including Members of Congress, in holding hearings on the bills he has drafted for his personal aggrandizements; that is, the Wagner-Murray-Dingell bills. A complete investigation of his public actions for the past decade should be initiated at once with a view to prosecution and punishment if found guilty of breaking Federal laws and of working for the overthrow of our constitutional form of government by substitution of a system of state socialism, including Federal social-security medicine.

MARJORIE SHEARON, Ph. D.,
Editor and Legislative Consultant.

APPENDIX

United States Senate,
Committee on Labor and Public Welfare,
June 26, 1947.

Willard C. Rappleye, M. D.,
Chairman, Board of Directors,
Health Insurance Plan of Greater New York,
New York 13, N. Y.

Dear Dr. Rappleye: During the hearings now being held on S. 545 and on S. 1320, we have been told repeatedly by proponents of one point of view that:

1. People do not want comprehensive coverage in prepaid medical care plans; that they prefer coverage limited, as in most medical society-sponsored plans, to surgical and hospital care.

2. It is impossible to offer comprehensive care because of the impossibility of controlling abuses in plans not restricted to catastrophic illness.

3. That administration of health insurance plans should be vested in doctors of medicine.

Inasmuch as I understand that your program is based on concepts other than those mentioned, I would appreciate a statement from you setting forth your position on these three matters, and any experimental evidence (your own or that of other groups) tending to support your position.

Please be assurred that I am not asking you to comment in any way on the relative merits of S. 545 or of S. 1320 and that your reply will not be interpreted as going beyond the questions of administration and of policy raised above. I shall, of course, be pleased to receive any comments you may choose to offer on S. 545 or S. 1320 but to prevent any possible misunderstanding, I would ask that they be made in a separate communication.

Sincerely yours,

James E. Murray, *United States Senator.*

(Identical letters sent Group Health Association, Washington, D. C., and Community Hospital, Elk City, Okla.)

Health Insurance Plan of Greater New York,
New York 11, N. Y., *July 14, 1947.*

Hon. James E. Murray,
United States Senate, Washington, D. C.

Dear Senator Murray: In reply to your letter of June 26, I am very glad to comment on the three questions you raise, from the point of view of the Health Insurance Plan of Greater New York.

(1) We have found that when people are offered insurance for comprehensive medical coverage at a price they can afford to pay, they are eager to secure it.

The HIP began service March 1, 1947, with approximately 2,500 persons insured. At the present time there are over 60,000 insured in our plan. This growth in 4 months, in our opinion, furnishes ample evidence that employed people in New York, at least, are eager for this type of coverage. Also, we have received hundreds of inquiries from individuals who have heard about the plan and want to know how they can participate.

In all of our contracts, including those with the city of New York and the United Nations, the employer pays at least one-half of the premium, thus enabling lower-paid workers to buy our insurance at a price within their means. Our total premiums are:

	Per year
Employees with no dependents	$29.04
Employees with 1 dependent	58.08
Employees with 2 or more dependents (without limit as to number)	87.00

The employer pays approximately one-half of these amounts. When the premium of the Associated Hospital Service is added to ours, the totals are as follows:

	Per year
Employees with no dependents	$42.00
Employees with 1 dependent	84.00
Employees with 2 or more dependents (without limit as to number)	120.00

In most cases the employer pays half of the Blue Cross premium also. Dependents are defined by New York State law as spouses and unmarried children under 18 years of age. Thus, the most that the employee with two or more dependents is called upon to pay is approximately $5 per month for both HIP and Blue Cross coverage. The rapid growth of our enrollment indicates that, at this price, people in New York enthusiastically seek insurance for comprehensive care.

We have found that one of our greatest attractions is the fact that our coverage includes health examinations, preventive care of all tpyes, and access to a physician without extra charge for even a minor illness. By this means our subscribers can secure treatment early in an illness, thus enabling the physician to prevent or mitigate complications and sequelae, which might otherwise result in serious disability. Our enrollment division informs me that people are more attracted by this feature than any other single point in our plan although, of course, they are also glad to have protection at the same time against the cost of catastrophic illness. In fact, in our experience, while people do complain about every limitation, they never complain about coverage being too comprehensive.

Our experience is by no means unique. Actually, medical-care insurance for comprehensive coverage has, as you undoubtedly are aware, a very long and successful history in the United States. The oldest plan in continuous existence is probable that of the Northern Pacific Railroad, which was started in 1882 and is still operating with great success. Other somewhat similar plans with coverage of a comprehensive character are those of Kaiser-Permanente Foundation, Oakland, Calif.; Endicott-Johnson Co., Johnson City, N. Y.; Ross-Loos Clinic, Los Angeles, Calif.; Trinity Hospital, Little Rock, Ark.; Farmer's Union Cooperative Hospital, Elk City, Okla.; Group Health Association, St. Paul, Minn.; Consolidated Edison Co., New York City; American Cast Iron Pipe Co., Birmingham, Ala.; Tennessee Coal & Iron Co., Birmingham, Ala.; Group Health Association, Washington, D. C.

Most of these plans have been in existence for many years and all are highly successful. There are many others besides those I have named but these are perhaps a sufficient number to indicate that insurance for comprehensive medical coverage is not unusual. All of these plans have found, as we have, that people are eager to secure this type of coverage and to maintain it when such an opportunity is offered to them at reasonable cost.

(2) The fact that the above insurance plans have been successful over long periods of time is in itself an indication that insurance for comprehensive medical care is not impossible to administer. Nevertheless, there are a number of important administrative problems in connection with providing comprehensive medical-care insurance. Problems arise, for example, concerning professional standards, clarification of benefits, mechanics of selection by subscribers of physicians and medical groups, efficient utilization of service, and relations between doctor and patient. To label such problems as "abuses" is to misconstrue the nature of a large insurance operation. Most of the same problems necessarily also occur in programs restricted to hospitalization only, or to service for catastrophic illness.

We believe that there are three points of great importance in developing workable comprehensive plans. First, enrollment of subscribers must be carried out through strict application of group insurance principles. For example, in the HIP no group smaller than 25 employees with a common employer or members of a common labor organization is accepted. Furthermore, each group of 25 or more must constitute at least 75 percent of the eligible employees in an enrollment unit. If group insurance principles are not adhered to, persons who expect to use the service will, of course, enroll in disproportionate numbers and persons who do not expect to use it are less apt to enroll, thus resulting in a subscriber load adversely selected and not a true cross section of the population. Some plans which have tried to offer comprehensive coverage have failed because they did not adhere to group insurance principles. Plans that have used the group insurance technique have found that, by securing a membership that approaches a true cross section of the population, both healthy and ill, they have good protection against abuse.

The second important point is the use of group medical practice in the delivery of medical service. Group practice has professional and economic advantages for physicians and patients alike, with which I am sure you are familiar. From the point of view of an insurance plan for comprehensive care, group practice offers, we believe, by far the best method of furnishing complete service without abuse. In a medical group, the physicians work as a team in cooperation, rather than in competition, with each other. Thus, all members of the group may seek the aid and advice of their fellows without financial disadvantage. Such teamwork makes for more thorough, more efficient medical service, tends to eliminate duplication of effort, and to stimulate high quality of care for the patient through the proper use of all the varied and specialized professional and technical skills of modern medical science.

The excellence of service offered by a medical group is in itself a safeguard against any tendency to abuse because patients satisfied with the thorough and painstaking care they receive are not beset by the uncertainties and anxieties that so often lead to repeated demands upon the doctor. Finally, a medical group offers an ideal medium through which subscribers may be educated about health and about the most effective means of utilizing medical services. Such health education, which is an integral part of HIP's program, and of many others, reduces unreasonable demands through clear understanding.

Most of the plans I have mentioned above use the group practice technique in the delivery of their service. There are a few exceptions in which comprehensive service is provided through individual physicians rather than group practice, but these are not numerous.

The third point is that in successful comprehensive plans physicians are generally paid by some other method than fee-for-service. Very few, if any, voluntary insurance plans for comprehensive care which pay physicians on a fee-for-service basis have succeeded in the United States. The HIP, for example, is to pay a medical group $20 per year for each insured person enrolled with that medical group. This amount is paid whether a subscriber receives service or not. In this way the group of physicians are assured of a stated income and the insurance plan has a clearly defined financial liability. When enrollment with a medical group reaches capacity (approximately 800 insured persons per full-time physician or his equivalent in part-time service), HIP's capitation payments are estimated to be sufficient to yield an average annual gross income of $16,000, or a net income of about $10,000, per full-time physician. Actually, no physician is obliged to serve HIP subscribers full time and each medical group is free to divide the funds received according to any legally permissible formula. Presumably, incomes will be proportionately less for physicians who serve part time. Other comprehensive insurance plans use part-time salaried physicians, full-time salaried physicians, have various types of partnership drawing accounts, or pay capitation like the HIP. The point is that, whatever the exact method used, most successful comprehensive insurance plans compensate physicians according to the time they spend and according to the degree of their skill, rather than by fees for each service rendered. Payment in accordance with time and skill rather than by fee-for-service removes an incentive to abuse on the part of the physicians. Instead, it provides an incentive for the doctor to keep his patients as healthy as possible and to treat them as efficiently as possible, thereby reducing the number of services he has to render. Payment by the fee-for-service method, on the other hand, puts no premium on keeping patients healthy and offers an incentive to multiply the number of services. Abuse has, in fact, been troublesome where comprehensive coverage has been attempted by this method.

(3) In our opinion, the administration of the professional aspects of a health insurance plan should be vested in doctors of medicine. In the HIP, all professional matters come under the jurisdiction of a medical control board composed of 15 outstanding physicians. The decisions of the medical control board on professional matters may not be altered by the board of directors, except with the concurrence of a majority of the physician-members of the board of directors.

With regard to matters of general policy, such as premium rates, enrollment, types of coverage and all other nonprofessional matters, we believe that ultimate authority should rest with a board of directors representing the public. Because it is the health of the public which is at stake, and because it is the people who are paying the cost of the insurance, we consider that the public should necessarily have the controlling voice in general policy. In the case of the HIP, the boards of directors includes eight members of the medical profession, eight from among employers, four from labor organizations, two from the city of New York and two from the field of social welfare. While many other types of composition for boards of directors could be devised, we feel that the important principle is that a majority of the board should represent, directly or indirectly, subscribers, employers and the general public rather than the medical profession. Where doctors of medicine have final authority in an insurance plan, the result is that the persons who stand to gain financially from the plan (i. e., the doctors), are also in control of its funds. This seems to us highly improper. An insurance plan is presumably designed for the protection of the health of its subscribers, as well as for the economic and professional advantage of its physicians. Doctors of medicine should have full control over professional matters and should be adequately represented on the board of directors, but ultimate control of medical insurance plans should, in our opinion, rest with the public.

I hope that these comments will give you the information you wish to have, but should you desire anything further, please let me know and I shall be glad to furnish you with additional data.

Very truly yours,

Willard C. Rappleye,
Willard C. Rappleye, M. D.,
Chairman, Board of Directors.

Group Health Association, Inc.,
Washington 7, D. C., July 22, 1947.

Senator James E. Murray,
United States Senate, Washington, D. C.

Dear Senator Murray: I welcome this opportunity to reply to the three pertinent questions regarding prepaid medical care programs which you raised in your recent correspondence. There have been much loose talk and unfounded conjecture on these three points. I shall attempt to state the facts as I see them based on the experience of Group Health Association in the operation of a prepaid medical-care program.

1. Do people want comprehensive coverage in prepaid medical-care plans?

This question can be answered best, perhaps, by citing a recent vote on this very question by the membership of Group Health Association. Due to the present inflation of prices, the Association recently was forced to increase its income. The issue was submitted to the membership for a vote. They were given the alternatives of increasing the monthly dues or of leaving the dues rate unchanged but paying for a part of their care on a fee-for-service basis. More than six times the number of members voted for increasing the membership dues than voted for introducing service charges.

From my experience I would say that the vast majority of people prefer a medical-care program that provides complete coverage. It is true, however, that under a voluntary plan where the cost of the service must be the same to all participants, regardless of income status, a large percentage of the population cannot afford to purchase the complete coverage which they want and need. In our recruiting of new members it has been common experience to find that persons having incomes of less than $3,000 per year want the comprehensive coverage offered by the Association but cannot afford to purchase it. For example, representatives of the Government cafeteria workers in the District of Columbia approached the association regarding medical care for this group of employees. These employees were anxious to have the complete health service offered by the association, but finally decided they could not afford such an adequate plan. They requested as an alternative that the association consider making available to them a more limited service that would fit their pocketbooks.

This experience typifies the process by which the majority of the people arrive at their so-called wants with regard to medical service. It is what they can afford rather than what they need and desire that determines their demands.

2. Is it possible to control abuses in plans not restricted to catastrophic illness?

Among families in the general population having incomes of $10,000 per year or more it has been found that on the average each member of the family visits the doctor about 5.5 times per year. It is assumed that persons on this level do not find the cost a barrier to getting adequate medical care. It may be assumed further that since they are paying for the service they are not purchasing more care than they need. Participants in Group Health Association, who have comprehensive prepaid medical care, visit the doctor on the average of about 5.4 times per year. This would seem to indicate that GHA members do not abuse the privileges of their membership.

There are, of course, some exceptions. A few individuals do attempt to overutilize the service. However, the doctor remains in the position of control, for he can, and in the association does, limit the services he will give to the patient who does not need medical attention.

3. Should the administration of health insurance plans be vested in doctors of medicine?

It is obvious that in a medical-care program the physician must take a major part in the control of the program. Insofar as medical problems are concerned the physicians must have full and complete control. In the operation of a medical care plan there are, however, many problems that are not medical in nature. There are problems of business management and problems of general policy that call for skills and judgments not required in the medical field. The physician may be trained in business management as well as in medicine, in which case he would be particularly well equipped to handle the management of a program. At the same time, a medical degree need not be a prerequisite for the executive administrator of a program. With regard to general policies involving the organization of the plan, dues rates, extent of coverage, and other such matters, certainly the membership of the program has a major interest. In my opinion the decisions on such matters should be made by the persons to be served by the plan or by their elected representatives. The representatives of the participants in such a program should include physicians either as voting representatives or at least as consultants.

To summarize, I feel that complete and final control over medical matters should be left to members of the medical profession, but that control over the basic policies of the program should be left to the participants in the program.

If these remarks do not cover some aspects of the questions you pose, I shall be glad to hear from you further.

Sincerely yours,

MELVIN L. DOLLAR,
Executive Director.

COMMUNITY HOSPITAL,
Elk City, Okla., July 2, 1947.

Hon. JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR MURRAY: Your letter to my father has been received and I hasten to explain that he is on a tour of Europe at the present time and will return to New York on August 3. Your letter is being sent to New York asking that it be held there until he arrives, at which time I can assure you that his answer will be forthcoming.

I have been connected with this institution for the past 6 years and it is my experience that people would welcome comprehensive coverage. In smaller groups this care would be quite expensive due to lack of numbers, but on a volume basis it would be offered at moderate costs. In your question No. 2 you mention abuses which might result other than catastrophic illness. We have seen no such abuses in our group. I do not believe that this would be true. The great draw-back to limiting people to catastrophic illnesses is there is no care being given to preventive medicine. Also periodic check-ups are not provided and neither clinic treatments nor examinations which are so essential. Administration of health-insurance plans should be made up of both doctors and laymen.

I greatly admire your stand on the national health legislation which is so sorely needed in our great Nation. I wish you could attend the annual meeting of Cooperative Health Federation (all prepayment groups) to be held here September 5–7. I feel it would be of great value to you.

Sincerely yours,

FRED V. SHADID.

STATEMENT OF MRS. ARTHUR FORREST ANDERSON, PRESIDENT, NATIONAL BOARD OF THE YOUNG WOMEN'S CHRISTIAN ASSOCIATION, NEW YORK, N. Y.

JUNE 12, 1947.

Health education has always been a major part of the program of the Young Women's Christian Association. The definition of health given by the International Health Conference in drafting principles for the World Health Organization is in essence the definition accepted by the YWCA, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

The national convention, meeting March 2–8, 1946, adopted the following statements in its public affairs program: Under the general heading Public Health, "Accepting the principle of the right to good health of every citizen in a democracy we reaffirm our purpose to cooperate with the Government and other agencies to make available to all people equally adequate health services and low-cost medical care. Inherent in such a program would be work on the prevention and control of disease and the protection of material and infant welfare."

Another section, entitled "Social Security," contains the words, "We will work for an adequate progam of health insurance."

In formulating its public affairs program the national convention of the YWCA does not take action on specific bills before Congress. The principles adopted in this program determine whether or not the national board should take a position on particular bills. If bills are considered, the national board decides upon action for itself, and the local associations make decisions for themselves.

It is on the basis of principles that we question the adequacy or desirability of legislation of the type embodied in the national health bill introduced by Senators Taft, Smith, Donnell, and Ball.

President Truman in his message to Congress on November 19, 1945, and again on May 19, 1947, said that a health program which would be necessary to the national welfare and security must include:

"1. Adequate public health services including an expanded maternal and child health program.

"2. Additional medical research and medical education.

"3. More hospitals and more doctors—in all areas of the country where they are needed.

"4. Insurance against the costs of medical care.

"5. Protection against loss of earnings during illness."

He pointed out that several important advances had been made toward the realization of some of these goals, but much remains to be done.

The methods proposed in the national health bill do not seem to be of the kind that would most efficiently bring about the desired goals. Instead this bill proposes the use of Federal funds by States to provide medical service on a charity basis to families and individuals with "low incomes." The separate States and Territories are apparently left to determine for themselves the definition of "low-income" people to be served, and the methods by which eligibility will be decided. How will they decide this? By subjecting people to some sort of "means test" or "pauper's oath"? Will this mean a return to the old poor-law philosophy which has long been rejected under accepted standards of public welfare?

How will dental health services for school children and families of "low income" be provided without placing the children in an embarrassing position with their schoolmates? Should not the needs of all children be recognized equally by providing periodic examinations and follow-up in a way that does not call attention to their economic status?

Under legislation of this kind States and local communities could, in effect, subject some of our citizens to a humiliating experience. Surveys have shown that adequate medical care is commonly too expensive for the low-income group. It is, nevertheless, a basic human need. To provide it under a plan of health insurance does no violence to personal dignity as would a "means test" such as would be set up under this type of legislation.

Undoubtedly many young employed women in the YWCA could be classified as members of a "low-income" group, but they all take pride in being independent wage earners. They wish to pay their own way in the world. If it is a struggle to do so, then they struggle with their budgets to pay for the things they need. One thing that does not fit easily into their budgets is medical care, espeically the cost of sudden illnesses. Cost-of-living surveys of the New York State Department of Labor included in calculating the cost of medical care for a single woman living at home: the cost of drugs, general and special examinations and treatments, payments on past illnesses, and a reserve for future needs. The 1946 survey showed that for adequate protection of health a woman worker living as a member of a family in New York State in 1946, needed $73.24 for medical care.

In 1944 and 1945, the National Council of Business and Professional Girls of the YWCA made a cost-of-living survey, sampling girls from all sections of the country. In summing up some results of the survey the national council president stated, "Our survey shows that too many girls spend absolutely nothing in the course of the year on the doctor, the dentist, and the oculist. Most of us are still young and healthy. Theoretically, we 'get by' without this care, but we are obviously ignoring the injunctions to have an annual physical check-up and to see our dentist twice a year."

The concern registered by the president of the National Council of Business and Professional Girls of the YWCA is borne out by local groups of employed women throughout the country. Studies made in several local YWCA's have shown that even when the girls are covered by hospital insurance, they frequently have high medical and dental bills in addition.

At our convention one business girl said, "Business girls' salaries generally are not high enough for them to set aside savings for an emergency health situation, and serious illness means a long-time debt; health insurance is of particular concern to business girls, for office workers have a high rate of respiratory diseases."

Under the provisions of the proposed national health bill, it is possible that such individuals might be declared eligible for some of the money to be allotted to people with low income. But when you multiply these cases of single employed women in the YWCA's alone, and add to these the cases where whole families are involved, one wonders how far the money will go, how many of the needy cases can be served, and what will happen to the self-respect of the individuals thus served. Large sums of money, both Federal and State, are needed just to serve the indigent—the people now on public assistance rolls or in institutions who are ill. But a supplementary system is needed whereby wage earners can remain independent and help to pay their own way. Insurance, spread over a large number of people, is a sound way of giving self-respecting wage earners help in meeting their medical needs.

Federal grants on a matching basis may be sound for other purposes—for hospital construction; for care of recipients of public assistance; for extension of research; for extension of educational opportunities and facilities for training more doctors, nurses, and health education personnel; for building up public health services in areas where these are lacking. All of these things are badly needed. But proposals that make it necessary for wage earners to be subjected to something like a means test should be rejected.

The YWCA is attempting to educate its members to have regular health examinations, and to take all proper precautions to prevent serious illness; to use available hospital and voluntary medical and surgical insurance plans; to support State and Federal legislation for decent working conditions and hours of work for women; to cooperate with local medical and public health officials and with community agencies in raising health standards throughout the country. Our educational process would break down, however, if our young employed women thought we regarded charity medicine administered by local and State governments as the answer to their needs.

CONSTANCE W. ANDERSON.

LETTER OF GUST ANDERSON, SECRETARY, CENTRAL LABOR COUNCIL OF PORTLAND AND VICINITY

PORTLAND 4, OREG., *July 7, 1947.*

Hon. PHILIP R. RODGERS,
Clerk of Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SIR: The Central Labor Council of Portland, Oreg., an organization affiliated with the American Federation of Labor and representing 75,000 workers in this community, is very much interested in health legislation which has been introduced in the United States Senate, and of which hearings are now being heard before the Senate Committee on Labor and Public Welfare.

The bill which we are interested in is S. 1320, entitled "National Health Insurance and Public Health Act." S. 1320 provides for a comprehensive national health program through a Nation-wide system of prepaid personal health-service benefits and through Federal grants to States for expanded health service.

It is but natural that the working people of this Nation and throughout the various communities are very much interested in Federal health legislation because hundreds of thousands of them are not able on their earnings to pay for medical, dental, and hospital service that is needed by the breadwinners and their families.

I believe it is fair to state that the population under prepaid medical care in Portland and throughout the State of Oregon is greater than in most States, yet it is not satisfactory because it is limited to only certain groups.

The following statistics covering the city of Portland, with 420,000 population for 1946, is respectfully submitted to your committee:

Health status of the population, 1946.—Death rate per 1,000 population, 11; infant deaths per 1,000 live births, 27; maternal death rate, 1946, 0.9; death rates per specific disease: Tuberculosis, 22; heart disease, 300.2 (100,000 population).

Health personnel.—One physician for every 544 people, 1946; 1 dentist for every 820 people covered, 1946; percent of population covered by a full-time public-health officer, 100 percent; per capita local health department expenditures, 65 cents.

General and special hospital facilities (excluding Federal).—Population per hospital community, 37,272; hospitals per community, 1.10; beds per community, 145; beds per 1,000 population, 6.3; percent of beds occupied, 84.8; average days of care per person, 12.2.

It is my firm opinion, in representing 75,000 workers in this community, that S. 1320 offers a fair and comprehensive program in health aid, and respectfully urge upon your committee to give this matter your earnest and favorable consideration.

Respectfully,

CENTRAL LABOR COUNCIL OF PORTLAND AND VICINITY,
GUST ANDERSON, *Secretary.*

STATEMENT OF H. B. ANDERSON, SECRETARY, CITIZENS MEDICAL REFERENCE BUREAU, INC., NEW YORK, N. Y.

The bill, S. 545, is predicated upon the idea that if we guarantee adequate medical and hospital care to the indigent; if we extend the activities of the United States Public Health Service; if we make dental and public-health services more readily available throughout the country, and if pay-roll deductions to provide health or hospital insurance are placed upon a voluntary basis there would be no need for a Nation-wide system of health insurance such as is now being proposed in the bill S. 1320, to provide a national health insurance and public-health program.

If it were a question of choosing between this bill and the bill providing for a Nation-wide system of compulsory health insurance we would, of course, be in favor of the bill S. 545.

However, in our opinion the bill, S. 545, would not eliminate the threat of additional centralizing legislation a year or two hence. The bill, S. 545, specifically declares it to be "the policy of the United States to aid the States, through consultative services and grants-in-aid, to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status." We maintain that this statement of policy is capable of the widest possible interpretation and that if enacted into law it might, and in all probability it would, be used a year or two hence as an argument in support of a system of compulsory health insurance as providing the only comprehensive system by which medical, hospital, dental, and public-health services could be made available to every individual regardless of race or economic status. The annual appropriation of $200,000,000 as provided in this bill would then become only a drop in the bucket compared to the billions upon billions of dollars involved in a Nation-wide system of compulsory health insurance.

We therefore are opposed to the passage of the bill, S. 545, on very much the same grounds, although to a lesser extent than we are opposed to the passage of the bill providing for compulsory health insurance.

We oppose the passage of the bill, S. 545, on the ground that the primary responsibility of the Federal Government in the field of medical care and public health is to maintain the economy of the Nation and that is a problem with which every agency of the Federal Government is equally concerned. We maintain that the principle of State aid enables the United States Public Health Service to carry out a compulsory medical program which robs the States and the individual of rights which properly belong to them. And we further maintain that health and medical care are of such a personal and highly controversial character and are so subject to medical exploitation that a system of overmedication such as we are now beginning to experience offers a far greater threat to the health of the Nation than any alleged lack of medical care or public-health facilities.

In our opinion, the solution to this whole problem of the provisions contained in the bill S. 545, as well as in the bill S. 1320, to provide a national health insurance and public-health program lies in a reexamination of the entire health structure of the country to determine exactly what activities having to do with medical, hospital, dental, and public-health work are the responsibility of the Federal Government and what activities properly come within the scope of State or local agencies of the Government.

If this were done we believe it would be ascertained that the first essential activity of the Federal Government in the field of public health is to maintain the economy of the country. We have only to note the appalling rise in mortality from tuberculosis and other diseases in European countries where the economy has broken down to realize how essential it is to preserve our own economy in order to safeguard the health of the Nation. We maintain that the State Department in seeking to maintain friendly relations with other nations; the Department of Commerce; the Department of Labor; the Department of Agriculture; and all the other departments of the Federal Government are in one way or another concerned with the problem of maintaining the Nation's economy. It is therefore impossible to coordinate the health functions of the Federal Government.

We believe that if the health structure of the country is reexamined it will be found that the responsibility of the Federal Government in public-health matters having to do with medical care is limited to such matters as international quarantine, the care of veterans, and safeguarding the health of the population in the District of Columbia.

In our book, Public Health the American Way, pages 25–40, we point out that over a period of 125 years Congress maintained a hands-off policy as regards medical and public-health activities in the respective States. In other words, it was not until the beginning of the present century that any legislation was enacted by Congress which would in any way interfere with the rights of the States in matters having to do with medical and public-health activities within their borders. But once the process of federalizing local medical and public-health activities gained a foothold the process has become accelerated with each passing year until today there are at least 20 major bills now pending in Congress, all of which if enacted into law would have the effect of federalizing medical and public-health activities which under our Constitution were intended to be reserved to the respective States.

As a result of the debates in Congress from 1910 to 1916 upon bills to establish a national Department of Health with a physician in the President's Cabinet it became quite generally recognized that medical and public-health work generally came under the police power of the respective States and were therefore a State or local activity.

But in 1919 an ingenious plan was worked out by which the Federal Government could continue to extend Federal control over local and State medical and public-health activities under the guise of respecting State rights. I refer to the plan for State aid by which the Federal Government advances moneys to the respective States provided they appropriate a like amount and then the States are required to submit detailed plans for approval by the Federal authorities, thereby enabling the Federal Government to control the expenditure of the moneys appropriated by the States as well as the moneys advanced by the Federal authorities. This is the plan behind the greater part of the legislation to extend the activities of the United States Public Health Service enacted by Congress during the past 25 years.

It is true that neither this bill nor any of the many other bills passed by Congress during recent years to extend the activities of the United States Public Health Service authorizes compulsory medication of any kind. In fact, many of the statutes enacted by Congress contain provisions directly providing that the legislation makes no such authorization. But the point is that the Public Health Service does not require any such authorization in order to carry out its compulsory medical program. All it needs is millions upon millions of dollars to distribute to the respective States provided they are willing to "cooperate" and this "coopeation" in many instances is reflected in the passage of laws in the respective States designed to make medical examinations or treatment compulsory.

The most recent example of this form of "cooperation" is the program being sponsored by the United States Public Health Service for the X-ray examination of all persons in the United States who are 15 years of age or more. In line with this program legislation is now beginning to make its appearance in State legislatures designed to make X-ray examination of employees and other groups compulsory.

The tuberculosis program is patterned very much after the venereal-disease program which the United States Public Health Service has carried on during the past 5 years. "Cooperation" by the States in the venereal-disease campaign took the form of legislation in the various States designed to make serologic tests compulsory.

What both of these campaigns fail to take into consideration is that the eradication of both of these diseases is largely a social and an economic problem and that compulsion retards rather than promotes the eradication of the respective diseases.

As previously stated health and medical care are of such a personal and highly controversial character and are so subject to medical exploitation that a system of overmedication such as we are now beginning to experience offers a far greater threat to the health of the Nation than any alleged lack of medical care or public-health facilities.

It is to be noted that the bill S. 545 provides only for medical, hospital, dental, and public-health services. It makes no mention whatever of any nonmedical form of treatment. Yet today, as in all ages in the past, there is a wide difference many millions upon millions of persons are known to be adherents of nonmedical profession.

In highly controversial matters having to do with the healing art, where many millions upon millions of persons are known to be aderents of nonmedical methods of healing, it would appear that if the Government were desirous of spending hundreds of millions of dollars of the taxpayers' money to provide care in time of illness that it would show the same interest in providing persons with nonmedical treatment who wanted that method of treatment as it does to provide medical treatment for those who desire that method of treatment.

In fact, the kind of medical treatment we would naturally expect from a federalized system of medical care is in the nature of what might be termed a "miracle medicine." It is the kind of medicine that makes the biggest headlines in the newspapers. It is not even the kind of medical care that the more conservative type of family physician would wish to prescribe.

In recent years the propaganda in favor of ever-increasing Federal appropriations to make possible this so-called miracle medicine has reached such alarming proportions that the entire Nation is being made disease conscious. Today we cannot pick up a newspaper or listen to the radio for 10 minutes without being reminded how many persons are going to die from some horrible disease. It is not surprising, therefore, that our mental hospitals are bulging over and that we are rapidly becoming a Nation of hypochondriacs.

That patients may actually become "paralyzed with fear" as a result of daily front-page press reports of new cases of poliomyelitis and the precautions to be taken is brought out by Richard H. Young, M. D., Omaha, Nebr., in an article entitled "A Clinical Syndrome Simulating Poliomyelitis," published in the New England Journal of Medicine, May 22, 1947.

Doctor Young cites five cases closely simulating poliomyelitis which were observed in private practice, in four of which the patients had hysterical paralysis of one or more extremities, during the week August 11 to 18, 1946, in Nebraska, and added:

"If a daily report is to be made, it might best be presented in an accessible part of the paper other than the front page, unless some emergency exists. A special effort should be made to appease any unreasonable fears of members in a family in which a case of poliomyelitis has developed * * * The response to reassurance and explanation in the cases in which there was marked fear because of association or exposure to patients with the disease suggests that the motor loss had as its basis an overwhelming fear, which caused a dissociation in motor activity. It is as though the patient had become 'paralyzed with fear.' "

I will close my remarks on this bill with two quotations. The first is a declaration by Oliver Wendell Holmes. I mention the quotation by Mr. Holmes to show how simple it would be for a few master minds in the Federal Government to prey upon the credulity of the public in matters pertaining to the healing art if Congress were to provide these master minds with millions upon millions or billions of dollars with which to carry out their plans for safeguarding the health of the dear public. Oliver Wendell Holmes in Medical Essays, pages 378–379, Boston, 1883, said:

"There is nothing men will not do, there is nothing they have not done, to recover their health and save their lives. They have submitted to be half-drowned in water, and half-choked with gases, to be buried up to their chins in earth, to be seared with hot irons like galley slaves, to be crimped with knives like codfish, to have needles thrust into their flesh, and bonfires kindled on their skin, to swallow all sorts of abominations, and to pay for all this as if to be singed and scalded were a costly privilege, as if blisters were a blessing, and leeches a luxury. What more can be asked to prove their honesty and sincerity?"

The other quotation I wish to bring to your attention is an editorial in a prominent medical journal pointing out that some patients look like pin cushions by the time they have had injection treatments for a cold, pains in the joints, or later, a pain in the neck and that they get "shots" for headaches, backaches, and heartaches.

[Copy of Editorial in the Detroit Medical News, Organ of Wayne County Medical Association, May 26, 1947]

The Callupin Poll of Public Opinion has been snooping around physicians' offices lately and have discovered that we are dispensing too many "shots." Most injections are given for good, sound physiological reasons—others for psychogenic effects—and others—for effect.

Diagnoses are made occasionally by history alone—the importance of physical examinations cannot be overemphasized. A patient may be advised to take a series of "shots" and they may be administered by a nurse or an office assistant and the patient may receive treatments for weeks or months at a time without the physician over examining them.

Some patients look like pin cushions by the time they have had injection treatments for a cold, pains in the joints, or later, a pain in the neck. They get "shots" for headaches, backaches, and heartaches.

Take a baby f'rinstance. Before she's even dry behind the ears, they give her a few shots of isotonic saline in the fanny just to get her used to what's coming later. A few months later they give her whooping cough shots, then vaccination, then diphtheria shots, then tetanus shots, then measles shots, intradermals then allergy shots, then autogenous vaccines; then a few "booster" shots for an encore.

If an adolescent boy starts to develop hills where there should be valleys he will get shots of something that causes a more manly figure to develop—if overtreated, he may have a "Van Dyke" at the age of 12—and other physiological improvements to match.

If an adolescent girl, she may get a few shots of some glandular extract if she seems bashful, underweight or overweight or cries when she should be laughing—and if the menarche is a bit late they might give her some potent hormonal product that puts her on the 28-day beam and gives her the rhythmic dithers for the next 30 years.

If she gets married and can't get pregnant, then they fill her full of antisterility shots and if she does get pregnant, they give her a lot more shots so she won't abort. Then if she does stay pregnant and is a few weeks overdue, they give her another shot to put her in labor—then with the new fangled O. B. methods they give her a "caudal" which is "shots" in a different spot—and some of those needles take large divots. Add to this all the shots for pain and sedation and you have sumpin—and don't forget vitamin B. And also injections for hemorrhoids and varicose veins.

Anyway, after having an average American family of 2¼ children and in a state of supreme exhaustion, she is made to submit to more injections to carry her through that alleged stormy menopause, somewhere between the ages of 40 and 80. At least that's the way we heerd it. When the male of the species has reached that "too old to dream" state, he too gets his shots to tide him over that droopy twilight period. The male, however, is more likely to associate "shots" with "Men of Distinction" than with parenteral therapy.

A common tactical error in therapeutics is treating an "anemia" with injections. without determining the cause or type of the anemia. Infrequent contact with their "personal" physician and infrequent and incomplete physical examinations are valid reasons for any patient's dissatisfaction with the present practice of medicine. A well-cared for and satisfied patient is the beginning of our public relations program and if this factor is minimized, then all of our individual and collective efforts in Lansing, Washington, and Moscow won't do us any good.

And now—the Benediction.

JAMES J. LIGHTBODY, M. D.

STATEMENT OF DR. SARAH BOWEN, MEDICAL DIRECTOR OF EMBUDO HOSPITAL, EMBUDO, N. MEX.

Mr. Chairman, members of the New Mexico Health Council: As we all know, the health problems in New Mexico are immense, as is evidenced by this 2-day convention where we can only hope to skim the surface of the matter, but when we consider the rural health problems against the urban situation, their magnitude is staggering.

We who live in New Mexico are proud to be citizens of the fourth largest State in the Union—a State of vast and magnificent distances, of unsurpassed grandeur and beauty, where more than 60 percent of the population is rural in character, living in communities of 2,500 or less on small ranches and farms. Yet, how many of us know of the health conditions prevailing in these rural communities? That our infant mortality rate is still the highest of all the States of the Union; that our maternity mortality rate is among the highest; that more than two-thirds of the deaths occurring in some of the rural communities are from unknown causes and that the deceased had never had medical care; that in some villages as high as 80 percent of the children suffer from some type of rickets; that dental caries is almost universal; that in some villages only 60 percent of the children every grow to adulthood; that defective vision and eye affections are very prevalent in those areas; that where a cross-section of the population was examined in one small rural area it was found that 100 percent of the people were anemic. One could go on listing cases of similar health handicaps which confront these rural people, and which are all reflected in the low physical stamina and a poorer life for all. These conditions are due not only to poor diet and poor health practices but also to the lack of adequate medical service.

In the State there are about 80 hospitals, general and specialized, with a bed capacity oof 4,700, 16 of these with 838 beds being located in Albuquerque, more than one-sixth of the number in the entire State. A few are found in the rural areas and these are small, poorly staffed, and often poorly equipped. Of approximately 300 doctors in the State, nearly half are located in Albuquerque and Santa Fe. As a result, medical facilities and medical attention are still hopelessly inadequate to the more than 60 percent of our population located in the rural areas.

In a country where the secondary roads are impassible to all but horse-drawn traffic for several months of each year it is not surprising to note that the services of doctors—just the cost of traveling alone—make it impossible for many of the people to secure trained medical attention in time of need. Our county health officers and nurses have rendered invaluable service in helping to improve health conditions but their services must be largely preventive and not curative. Because of this many of these people rely on patent medicines, native herbs, local midwives (often untrained) "medicos." These are enterprising individuals, home-made psychiatrists who deal in several lines of business. I often recall the time when, returning from a clinic held in an isolated mountain village, I was stopped by a local medico some miles from the hospital. His patient lay on a couch in his living room, and as I examined her, he continued with his cement work in the front yard making grave markers for the community.

He apparently believed in getting the sick both coming and going. Under these conditions it is not surprising that the people have all too often developed a fatalistic philosophy toward sickness and death and recognize in them "the will of God." Health superstitions and witchcraft still influence considerable numbers of our people in the rural areas.

We all realize that the healing of the sick is fundamental to civilization. In this twentieth century we should find a way to bring better health to all of the people in our so-called enlightened land. Standard services should be made available to all the people and yet we must take care of the professional rights and needs of those who render these services. In our rural areas where the families are often large and the annual income small, for a family of six often less than $1,200 cash a year, how can we solve the problem?

People are already finding it hard to get work, yet the cost of living is going up. Right now it costs those who live 12 to 18 miles from our little hospital $10 to $15 cash to hire a car or truck to bring a patient to the office for examination only. There is no public means of transportation over many of the secondary and tertiary roads to the little mountain villages and hamlets where the people live. I think of a young couple who last month brought their only son, a baby of 1 month old, to the hospital. He had been severely ill for 2 days before they could find a way to get down out of the mountains to a doctor. En route to the hospital (a distance of 40 miles) they had been told that the case was hopeless, his fever was 107, and that they would have to take him home to die. This they could not do and, at the suggestion of the truckdriver, they brought him the 25 miles further to our hospital. What this trip cost these parents we do not know, but in their sight it was worth anything, for their son was alive today. The father will probably spend several years working off the bill for this single illness and the transportation to the hospital. For our people do not ask for charity; they are willing and eager to pay for services rendered, but those charges should be brought within their means and not penalize a family for years.

This problem of rural health in New Mexico must be approached from many angles: (1) Through health education in the schools, through county health nurses and officers, through the Red Cross, tuberculosis association, and all other agencies interested in bettering the condition of the people; (2) through dietary improvement, county agricultural agents, nutritionists, etc.; (3) through preventive medicine, department of public health, and school examinations with follow-up corrective and remedial clinics; (4) through sanitation—pure water supplies, which are not existent in most rural communities now, (*a*) as a result typhoid fever and dysentery are always with us, (*b*) sewage disposal, (*c*) rural electrification; (5) through roads, which will make medical services and hospitals more accessible to the people and also help them economically by providing all-year-round farm-to-market roads; (6) and, finally, through curative medicine, more and better medical facilities for the care of the sick.

In this State there are no county hospitals nor adequate facilities for the care of the low-income rural population. Something fundamental in social planning and action is needed, where all agencies will cooperate and work together toward a solution of this problem. But, how can it be done? About 55 percent of the land in New Mexico is Federal or State Government-owned and not subject to State or local taxation which might help finance a health program. Does the solution lie in State medicine-socialized medicine?. No. 2. In a voluntary prepaid medical service plan? I doubt if they can meet the need for many of the rural people who live too near the subsistence level. Or, 3, must we develop organizations somewhat on the line of the Taos County Cooperative Health Association? It seems to me that the latter comes nearest now to meeting the needs of the people in our rural areas. We need small health centers located in key points, well equipped for emergency service, staffed with well-trained workers, demonstration centers for sanitation and health education, where well-trained and qualified physicians will make regular visits for examinations and to care for the ambulatory sick and contact the larger medical and hospital centers. Also ambulance service should be available. In these secondary centers most of the ordinary illnesses requiring hospitalization can be handled and cases referred to medical centers where specialists' services may be had, and modern medical equipment is available.

Right now such a solution may seem like an utopian dream. With the economic level of vast numbers of our rural population below the subsistence level; with the people themselves unaware of the needs and unwilling to be taxed for even the minimum health needs; with the scarcity of trained medical personnel in our urban areas to say nothing of the rural areas, it may seem hopeless.

But that is why we are here now. That is why the New Mexico Health Council was organized. That is why we all, everyone interested in this land of ours and the future of its people, must work together and strive to lift up the lot of the common man—the forgotten people in the rural sections of New Mexico.

Letter of Newton I. Burnett, Secretary, Hamilton Trades and Labor Council, Hamilton, Ohio

July 8, 1947.

Mr. Philip Rodgers.
Committee Clerk, Senate Labor and Public Welfare Committee.

Dear Sir: Thank you and Senator Robert A. Taft for allowing me the opportunity to file a brief opposing bill (S. 545) and supporting bill (S. 1320).

The national health insurance and public health bill, S. 1320, provides for a comprehensive national health program through a Nation-wide system to States for expanded prepaid personal health service benefits and through Federal grants to States for expanded health services. All the essential principles of national health insurance are maintained. It is to be administered by a board instead of a single Federal officer. It gives each person the right to choose his family doctor or any other doctor that he believes will give him the desired results. It also provides for advance payments for the services, which shall be deducted from the salary of all participants.

First, I would like to state that labor is heartily in favor of carrying a security plan which will take care of him when he is in need of medical assistance, but he does not care to have to apply for a charity hand-out and be shoved around from place to place and asked personal questions as to his ability to pay for the services. In order to show you systems used by the Blue Cross hospital and medical care and the compensations commission of the Post Office Department and the inadequate and unjust treatment they give you, I shall relate to you two cases which occurred in the Hamiliton, Ohio, post office. You probably do not care to know the names so I will omit them. However, I am in a position to furnish the names and cases with dates.

The first case is a letter carrier who slipped on the slick street and fell on his load of mail. He fell in such a way that he jammed up his spine. At first it was very painful, but after walking some time to finish his tour of duty it cleared up and he felt that the injury was so slight that he did not report the fall. Two months later he became ill and was not able to work, still he was not ordered to the hospital so that his hospital care could be called upon to help pay for his treatments. He called upon a specialist in Cincinnati, Ohio, and the doctor diagnosed his case as heart trouble, high blood pressure, and arthritis of the spine. After going to this doctor for 10 months his arm went to sleep and could not be waked up. The doctor told him that the arm was nothing to worry about. The patient told the doctor that he was not satisfied with the progress of the treatments. The fact is he was worse off than he was the first time he visited the doctor. Being discouraged with the way he was getting along, he decided to go to a clinic in Missouri where they use osteopaths, chiropractors, and medical doctors. They found that the fall had injured the spine and several of the vertebras were out of place which was causing his arm to go to sleep and his general disability. After a month's treatment the arm was normal and the man was able to do part-time work and gradually worked back to full-time duties as a letter carrier. He called upon the Blue Cross hospital care for assistance in paying for the services. They refused stating that the clinic was not a member of the association. He also called upon the Post Office Compensation Commission and furnished a medical doctor's statement that the fall which the carrier received while on duty was the cause of his disability. The Compensation Commission said that they were very sorry but that the Postal Laws and Regulations, sections 15 and 17, stated that all claims had to be presented within 1 year after the accident occurred and they could not do anything for him. The fact is, his first doctor horsed him around the year and he was not able to put in the claim until about a year and one month.

The second case I wish to present to you happened in 1945. This carrier was walking down slick steps and his feet slipped out from under him. In the fall he hit the back of his head on the steps. He felt pretty well jarred up and reported the fall but did not receive medical aid at that time. In about 2 months he became very ill and was rushed to the hospital and had to be kept alive with feeding him through the veins. The doctors could not decide what was wrong with him till he told them of the fall. Practically all the doctors told him that his trouble was from a bruised nerve in the back of his head caused by the fall. He filed a claim with the Post Office Compensation Commission and furnished a statement from his family doctor giving the cause of his disability as the result of the fall. He also furnished a statement from a witness that saw him fall. The Commission refused to give him any recognition. It is my opinion that the Post Office Department spent more money in trying to prove that his family doctor and the witness was a liar, than it would have cost to pay for the entire compensation claim.

I believe these two examples proves that the security given by the Blue Cross hospital care and Compensation Commission is not ample to take care of the present need. They have as many loopholes as many insurance policies. Just when you need care most they let you down. Many laborers are injured or sick enough that they cannot work but are not bad enough to go to a hospital and are not afforded proper assistance. A majority of the American families try to give their children the best advantages possible. It takes most of their wages to pay their living expenses and taxes, leaving very little to pay the extremely high prices the doctors charge.

Bill (S. 545) provides for only a beggar's chance for health assistance and it is my opinion that it will be carried out in a similar manner as the Blue Cross plan and Compensation Commission. When a person is sick or injured he is in no shape to be carted all over the country trying to prove that he is a bum or that he is trying to get assistance when he can pay for it himself.

I would like to refer you to the present social-security system which Congress put into effect. It is a wonderful system and every working man, woman, and child contribute their part. Up to the present time I have much praise and no criticism. It is my opinion that a national health insurance law should be made compulsory and worked on the same bases as social security. Although S. 1320 does not have the compulsory clause, your committee could insert the provision. The chiropractors and osteopaths should be allowed to be called upon for the kind of work they can do. The medical profession has shown in their various plans, such as the Blue Cross Hospital and Medical Care, which they have in operation, have demonstrated a monopolistic attitude. In many cases they are not trained to do the kind of work that needs to be done to relieve the patient. It has been proven to my satisfaction that the medical profession is not capable of taking care of many cases, but they are too conceited to admit their inability to do the work. For example a letter carrier slipped on a slick porch and dislocated a vertebra and was sent to the medical doctors for treatment. After playing him around for 10 days, in taking X-rays and consultations they recommended diathermic treatments and a light massage. This relieved him to a certain extent, but did not correct the trouble. He told them that they had not corrected the trouble. They in turn recommended a back brace and ordered him back to work. After several appeals to the medical doctors, with no results, he had to go and have his back fixed up at his own expense. The compensation law provides that a person injured while on duty shall have his medical bills paid, but the medical doctors have to recommend the treatment. The same provisions are in the Blue Cross Hospital Care policy.

My entire interest in this matter is that the working man, woman, and child be given the right to have just as good medical care as those that have plenty of money to pay for their services. No one knows just how or when they will become ill or seriously injured either on or off duty. They have no way of telling just how much they will have to spend to get well. In many cases such as the boys that are trying to establish a home at the present time are subjected to unreasonable prices for property or rents and in cases of illness it would be a wonderful help to have the hospital and doctor bills paid through deduction from their wages in advance. They would not miss the small amount deducted each month, but if they were to be ill for several months and have a hospital and doctor bill of several hundred dollars it would be a disaster. Under the bill (S. 545) he would have to beg to get assistance. If he had a home with considerable value, even though it were not paid for, the investigators would say that a man with such a valuable home should not be entitled to assistance. An unfair angle of this bill is, that many people save and try to be able to pay their bills, while others spend all they make in having a good time, taking no thought that some day they may get sick and be unable to work and pay their just debts. These people will not hesitate to call upon the plan to help them, for they will not care to be investigated and found to be a bum. The fellows that want S. 1320 to become a law are fellows that feel a responsibility of themselves and their family. They want to be able to afford the best medical care possible in case they are injured or ill.

If the Taft bill were to accomplish the goal set forth in section 2 (c); namely, "That it is the policy of the United States to aid the States, through consultative service and grant-in-aid, to make available medical, hospital, dental, and public-health service to every individual, regardless of race or economic status," it would prove an almost insuperable tax burden on the American people, especially during a depression. The small amount of money appropriated, however, and the methods of distributing medical care outlined in the bill give no indication on the part of the sponsors that they are really attempting to meet adequately the country's health needs. This bill serves merely as a temporary stopgap in the ever-increasing demand for more and better health service on the part of the American people. It offers no permanent solution.

Advantages of the Wagner-Murray-Dingell bill, S. 1320, over the Taft bill, S. 545:

1. Insurance versus charity: S. 1320 allows a worker to pay his medical bills through insurance instead of resorting to charity, as the Taft bill now provides. The means test, made necessary by the Taft bill, will discourage many people from asking for the medical care they need.

2. Comprehensive medical care versus incomplete medical care: S. 1320 provides for comprehensive medical care, instead of relying largely, as does the Taft bill, on the incomplete service offered by most voluntary plans.

3. Increased supply of doctors and hospitals versus present supply: In order to create the personnel and facilities necessary for meeting the goal set forth in (2), S. 1320 provides grant-in-aid for medical research and education and the construction of health facilities. The Taft bill makes no similar provisions.

4. Lower costs: Nation-wide coverage and no advertising and promotional costs means S. 1320 can offer more service at a lower rate than that offered under present voluntary prepayment plans upon which the Taft bill largely relies.

5. Eighty percent coverage versus twenty-five percent (Taft's figure) coverage: Through a pay-roll deduction S. 1320 will cover between 80 and 90 percent of the population in contrast to the small number the Taft bill seeks to provide with "charity" care.

6. Decentralization: The new S. 1320 allows for decentralization through State administration, but not at the sacrifice of maintaining minimum standards of medical care. The only function of the Federal Government under the Taft bill would be to grant money to the States, with the broad requirement that the money be used to carry out the general purposes of the bill.

7. Preventive medical care: S. 1320 encourages preventive medical care, inasmuch as workers and members of their family can secure periodic check-ups under the insurance plan. The reliance placed by S. 1320 on present plans means that hospital and surgical care is given—with few exceptions—after illness has struck.

8. Better distribution of doctors and hospitals: S. 1320 will bring about a better distribution of hospitals and doctors because people in rural areas, through the insurance system, will then be able to pay for their medical care. S. 545 would seek to accomplish this end by having the Government subsidize doctors to get them to go out and practice in economically poor areas. Here again the contrast is between the independence and self-reliance achieved through S. 1320's insurance program and dependence on hand-outs from Government as provided in the Taft bill.

9. People's controls versus doctor's controls: S. 1320 provides a major role for consumers of medical services on National, State, and local advisory committees, with the added provision that local professional committees be set up to advise on purely technical questions concerning the medical profession. The Taft bill would put the whole program in control of the doctors from the Administrator of the National Health Agency on down through the advisory committees. No specific provision is made for representation by consumers of medical service.

10. People want national health insurance: According to public-opinion polls taken by the Washington Post, National Opinion Research Center, Gallup, Fortune, and even the National Physicians Committee, the American people indicated a strong preference for national health insurance. The latest poll, taken by the Washington Post in February 1946, reported 70 percent of the residents of District of Columbia in favor of national health insurance.

Summary: The Taft bill makes the sad admission that there is no other way for a quarter of the population to meet its medical bills except through charity. S. 1320 denies this.

By setting up an insurance system through which people can spread the cost of medical care over the span of their working lives, S. 1320 provides the American people with a way to receive comprehensive medical care and at the same time their self-respect.

The Hamilton Trades and Labor Council has by popular vote endorsed this brief, and most respectfully request that bill (S. 1320) be enacted into law.

Respectfully submitted by—

NEWTON I. BURNETT.

STATEMENT OF THE CITIZENS' COMMITTEE TO EXTEND MEDICAL CARE, CHICAGO, ILL.

JULY 10, 1947.

(See pp. 2571–2615 and 2630–2646, vol. 5, hearings before the Committee on Education and Labor, United States Senate, on S. 1606, national health program, June 25, 1946, testimony of Alton A. Linford and Dr. Laurence Jacques, presented for the Citizens Committee to Extend Medical Care.)

Affiliated organizations: American Association of Medical Social Workers; American Association of Social Workers; Chicago Federation of Settlements; Chicago Industrial Union Council; Church Federation of Greater Chicago; Civic Medical Center of Chicago; Group Help Cooperative; Illinois Industrial Union Council; Independent Voters of Illinois, Inc.; Industrial Areas Foundation; Loyola University School of Social Work; National Lawyers Guild; Old Age Assistance Union; Social Service Administration Club, University of Chicago; United Office and Professional Workers of America, CIO; United Public Workers of America, CIO.

The Citizens Committee to Extend Medical Care urges the defeat of Senate bill No. 545, and it supports the prompt enactment of Senate bill No. 1320. The National Health Act of 1947 represents an unsound, inadequate, and undesirable method of meeting the medical and health needs of this Nation. It pretends to solve this widespread national problem by offering medical care to a few persons on a charity basis.

The National Health Insurance and Public Health Act of 1947, on the other hand, embodies the sound principle of insurance and would enable most of the families of this country to pay for their medical care in advance while they are working and able to afford it. By employing the insurance principle, this bill would in contrast with Senate bill 545, enable the American people to obtain needed medical care on a dignified and self-respecting basis without the necessity of a needs or charity test. We believe that the enactment of Senate bill 1320 is a logical and desirable step in the direction of improving and completing this Nation's system of social security.

Most of the workers of this country are already protected against the economic hazards of unemployment, old age, industrial injury, and death. We believe that the people want and expect their Government to extend this great system of social insurance to include the costs of medical care and wage losses resulting from illness and disability. We endorse Senate bill No. 1320 because it would extend our social-security system to cover medical expenses.

Since the Senate Committee on Education and Labor was good enough last year to hear the reasons why the Citizens' Committee supported a national health insurance program, that discussion will not be repeated here. We continue to support national health insurance, and for the same reasons. We should like here, rather, to discuss the basis for our opposition to the National Health Act of 1947 (S. 545).

The Citizens' Committee is completely and unalterably opposed to Senate bill No. 545 (misnamed the National Health Act) because it employs undesirable and intolerable methods and because it will not enable the great bulk of the American people to insure themselves against the costs of medical care. Our opposition is based upon the following unsound and undesirable features of the bill:

(1) The coverage provided by the bill is too narrow and restricted. It is a grave error to assume that only the indigent or low-income families in this country desire or require the assistance of their Government in securing needed medical services. Because the incidence of illness, its duration, and its cost are unpredictable, and because good medical care is becoming increasingly more costly, only a small percentage of the Nation's families have incomes and resources sufficient to purchase possibly needed medical service without bankrupting themselves. The American Medical Association stated in 1939 that families having incomes under $3,000 per year could not pay for medical care required in

a major illness (Factual Data on Medical Economics, p. 90). In 1939 almost three-quarters of the 33,000,000 American families had incomes of $3,000 per year or less. Since that time family income has increased materially, but so have the general costs of living; the costs of medical service particularly have increased markedly during these years. We believe almost as large a percentage of American families today would experience inability to pay for needed medical care as in 1939. The committee on the costs of medical care estimated in 1932 that "on the present fee-for-service basis it is impossible for 99 percent of the families to set aside any reasonable sum of money with positive assurance that that sum will purchase all needed medical care." (See Medical Care for the American People: The Final Report of the Committee on the Costs of Medical Care, p. 19.)

Since the need for health insurance is almost universal, it seems fantastic that anyone could seriously support a measure designed to cover only 20 percent of the families or sincerely believe such a measure sufficient to meet the extensive medical problem. A medical program for only the 20 percent in the lower-income brackets would be less than a halfway measure. All of the families in this country should have an opportunity to participate in a system of sickness insurance that would enable them to insure against the costs of medical care. This committee cannot agree with the bill's inherent implication that, because this low-income group (i. e., the lower 20 percent) has never enjoyed the freedoms and blessings of American democracy, we need not now be concerned about their wishes to have good medical care on the same basis as their more fortunate fellows. To toss them a few crumbs of charity, as this bill proposes to do, would perpetuate a vicious system of charity medicine.

The Citizens' Committee is aware of the claim that all but the lowest-income families may secure such insurance protection from one or more of the private voluntary prepayment plans operating at present. In our testimony last year we presented evidence of the inability of voluntary plans to provide adequate protection to all nonindigent persons, and also of the current efforts of organized medicine to establish a monopoly for their own inadequate and restrictive prepayment plans. We reiterate our belief that the voluntary plans cannot and will not ever afford extensively needed protection against the burdens of expensive and unpredictable illness. The people have a right to provide such protection for themselves through their Government. It can be provided in no other way.

(2) Not only are the services of Senate bill No. 545 limited to a relatively small group in the population, but even for this group the medical care provided is available only as medical charity. Needed medical services should be available on terms that permit their use on a dignified and self-respecting basis. Requiring a means test investigation in order to qualify oneself for needed medical care has the effect of placing upon its recipient an intolerable stigma. Charity medicine with all of its attendant demoralizing investigations is no more justifiable than charity schools, charity parks, and charity unemployment benefits. Chances of successful medical treatment are closely tied up with early diagnosis, prompt treatment, and the mental condition of the patient. Imposition of a means test would have the effect of delaying treatment for some and would tend to engender in the patient a sense of social inadequacy, defeatism, and demoralization that would hinder recovery. Inclusion of the means test would require an army of investigators that would materially add to the cost of administration. Such money could better be used to purchase needed medical care.

(3) The bill offers no basis for a sickness-prevention program but rather contains features that would positively discourage preventive action. Because of the financial obstacle many persons delay seeking medical attention until a disease is well advanced and when hope of successful treatment has diminished. Under the terms of this bill a person is ineligible for medical service until he is both ill and destitute. A good medical program which removes the financial obstacle would encourage persons to seek regular medical examinations and the earliest possible treatment of illness and of conditions leading to illness. Even after waiting until they are both ill and destitute, many individuals will further delay seeking the medical services provided by this bill because they will not wish to submit themselves to the humiliating investigations incident to the means test. The deterrent features of this bill, by delaying and discouraging early medical treatment, will add immeasurably to the eventual costs of medical service for those persons for whom this bill is intended.

In contrast, a person insured under a national health insurance program would be encouraged to have regular medical examinations and to seek the medical care promptly when it is needed. Under this type of program the financial obstacle would be eliminated and the individual would be likely to seek service promptly and as often as needed because he would feel that he has already paid for it, and he could receive it not as charity but as a right.

(4) The bill encourages the States to provide medical services to the indigent by subsidizing the private voluntary prepayment plans operating within the States. Of itself this might be a defensible stopgap arrangement; but in view of the medical society monopolies that are rapidly being established in the several States, we think that it should be opposed with all the strength that can be mustered. A comparison of prepayment plans sponsored by State and local medical societies with such plans as Health Insurance Plan of Greater New York, Labor Health Institute of St. Louis, Civic Medical Center of Chicago, and Group Health Association in Washington, D. C., shows these latter to offer a far more comprehensive medical service to be superior in every way. Yet such plans undoubtedly would not be permitted to participate in the services provided by Senate bill No. 545. The bill through its national and State councils places effective control of the administration in the hands of organized medicine. Since organized medicine continues to oppose any and all voluntary medical insurance plans which they themselves do not control and operate, they could be depended upon to see to it that only their own prepayment plans received any of the Government subsidy provided by this bill.

A further point to be made in this connection is that organized medicine is proceeding as rapidly as possible to secure State legislation that in effect permits no group except a medical society to set up and operate a voluntary medical insurance plan. (See pp. 2581–2594 of our testimony last year for details on this point.) By thus preventing any other groups to organize and operate voluntary medical insurance plans (in spite of the obvious inferiority and general restrictiveness of organized medicine's plans), they effectively limit experimentation and free enterprise in this field. For the Government to grant to organized medicine such a large measure of administrative control over public funds, and to permit the subsidy to be used exclusively by these monopolistic and generally inadequate plans, would plainly be contrary to the public interest and welfare.

In summary, we urge the defeat of Senate bill No. 545, because it does not meet the health and medical needs of the Nation, because it offers charity medicine instead of medical care as a right, because it will not encourage preventive medicine, and because it will constitute a public subsidy to a restrictive, generally unsatisfactory, and monopolistic network of medical-society operated prepayment plans. From every point of view, a far more satisfactory program would be a national health insurance program such as is embodied in Senate bill No. 1320.

Letter of Harry Cohen, President, Baltimore Federation of Labor

June 6, 1947.

Senator Millard Tydings,
Washington, D. C.

Esteemed Sir: The Baltimore Federation of Labor has given due consideration to the National Health Insurance and Public Health Act, Senate bill 1320, as well as Senate bill S. 545, introduced by Senators Taft, Smith, Ball, and Donnell.

After much study of these two items, we find that S. 545 is based on the charity principle and we believe would work an extreme hardship on any individual who might require aid. We are, therefore, unalterably opposed to this measure. We are, however, on record as being 100 percent in favor of S. 1320 and sincerely urge your support of this measure.

Won't you be kind enough to advise Senator H. Alexander Smith, chairman of the subcommittee, that we are opposed to S. 545 and favor the passage of S. 1320 and that we would appreciate his advice when hearings are scheduled to take place on these measures.

Thanking you for your cooperation in this item and for your past favors, we are, with every wish for your continued success,

Respectfully yours,

Baltimore Federation of Labor.
Harry Cohen.

STATEMENT OF CONSUMERS UNION OF UNITED STATES, INC., NEW YORK, N. Y.

Consumers Union, a nonprofit consumer testing organization with over 125,000 subscribers throughout the United States, urges the Senate Labor and Public Welfare Committee to reject S. 545 because it does not meet the urgent health needs of the American people. S. 545 would simply authorize Federal assistance to the States to provide charity medical and dental care for the poor. As such, the bill would be an extension of the present system of relief medicine, when what is needed is a comprehensive national public-health program to provide adequate medical and dental care to the entire population.

S. 545 fails to provide for the appalling health deficiencies of the Nation because it is based on an erroneous premise. According to Senator Robert A. Taft, a sponsor of S. 545, the bill "proceeds on the theory that the United States already has a comprehensive medical service * * * but that there are gaps in that service, particularly in reaching the lower-income groups." This statement cannot withstand critical analysis.

For example, one of the most glaring deficiencies in S. 545 is its lack of provisions for adequate public health services. Some 40,000,000 Americans still live in communities without full-time local public health departments. There are not enough public nurses, not enough trained sanitary inspectors, not enough laboratory personnel and dental hygienists.

The fact is that the Nation, as the war disclosed, has a serious shortage of hospitals, physicians, dentists, and nurses. More than that, those that the country has are unfairly distributed. Rural areas and smaller communities, in particular, suffer from an acute and chronic shortage of physicians, dentists, and nurses, and hospital facilities. The over-all shortage and acute regional deficiencies can be overcome only by a large-scale national program to expand educational facilities and to construct hospitals, clinics, etc.

This expansion must be geared to a national health system that can finance and provide adequate medical care for all our people. Otherwise, the distribution of hospitals, physicians, dentists, and nurses will be determined by regional and community ability to pay. Doctors and dentists are reluctant to settle in rural areas where there are few prospective patients, or in communities where most patients cannot afford to pay for their services. Similarly, the experience of decades has demonstrated that rural areas and small towns do not have public or private resources for building and maintaining modern hospitals.

S. 545 thus dodges the real health issue that confronts the Nation—the great majority of the American people do not receive adequate medical care because they cannot afford to pay for it. Medical costs are sudden and unpredictable, and most families do not have large enough incomes to budget adequately for any possible medical contingency. And since medical costs are so high today, millions of families must postpone essential medical care and preventive treatment. The productive capacities and energies of a large part of the population are wasted because of poor health that could have been prevented or remedied.

President Truman in his recent message to Congress on the need for an adequate Federal health program pointed out that we must not "permit our children to grow up without a fair chance of survival and a fair chance for a healthy life. We must not permit our rural families to suffer for lack of physicians, dentists, nurses, and hospitals. We must not reserve a chance for good health and a long productive life to the well to do alone. A great and free nation should bring good health care within the reach of all its people."

S. 545 would not enable the Nation to attain these necessary health objectives. It would give some measure of assistance to the indigent and those who are just on the border line of relief. To qualify for medical care under S. 545 an applicant would have to pass a means test, to admit that he seeks charity. The average American, however. does not want charity; he should not be forced to seek free care only after he has been reduced to dependency. He should be provided with protection against sickness just as our social security legislation provides him and his family with some protection against the insecurity of unemployment, old age, and death.

Furthermore, S. 545 does not even guarantee complete medical care for the needy. The States will decide whether they will provide hospital care only, or home and office care as well. The bill makes no provisions for nursing care, laboratory and diagnostic service, or medicines and medical appliances.

Each year thousands of mothers die needlessly in childbirth. Tens of thousands of babies die who could have been saved by proper medical care. Hundreds of thousands of children, crippled by accidents, rheumatic fever, or sight and hearing defects, have their lives deformed and their value to the Nation impaired because their families cannot pay for remedial treatments. Yet except for one provision for school health services, S. 545 does not provide for the health needs of mothers and children.

S. 545 is not a national health bill. It is a pauper health bill that would furnish a meager medical dole to those willing to humiliate themselves by taking a degrading means test. Instead of public charity, the American people require and should get the best medical and dental treatment. The way to meet this need is through national health insurance. This would spread the risk and the cost among the entire people so that individual families would not be faced in the event of a major illness with burdens that their incomes do not permit them to assume. Through a national-health insurance program, all our people can be covered and be entitled to medical, hospital, and related services.

As President Truman has said: "An insurance plan is the American way of accomplishing our (health) objective. It is consistent with our democratic principles. It is the only plan broad enough to meet the needs of all our people. It is—in the long run—far less costly and far more effective than public charity or a medical dole."

An adequate national health program must be based on this fact: Millions of American families, and not merely the poor, cannot afford to pay for the expense of a serious illness. To provide all families with the medical and dental care they need and should have, a national health program must include:

(1) A national system of health insurance to cover all the costs of medical care.

(2) Protection against loss of income during illness.

(3) Adequate public health services, including a greatly expanded program for maternal and child care.

(4) A comprehensive program for expanding medical research and education.

(5) Adequate medical facilities and personnel in all areas of the country where they are needed, so that rural communities and small towns can also have the best that is available in the way of medical care.

Such a program has been outlined in the provisions of the latest version of the Murray-Wagner-Dingell bill. This legislation should be considered by the Senate Labor and Public Welfare Committee and reported out as soon as possible. The welfare and security of the Nation are being undermined by the inability of the overwhelming majority of the people to obtain adequate medical care. This committee and Congress have the responsibility of acting upon the appeal made by the President "to give immediate attention to the development and enactment of national health and disability insurance programs."

STATEMENT OF PAUL B. CORNELY, M. D., WASHINGTON REPRESENTATIVE, NATIONAL MEDICAL ASSOCIATION

JULY 1, 1947.

The National Medical Association which is composed of approximately two-thirds of the 4,000 Negro physicians in this country and which is separate and distinct from the American Medical Association supports S. 1320, known as the National Health Insurance and Public Health Act. This position was reinforced when at its annual meeting in August 1946 it approved the testimony presented by its president, Dr. E. I. Robinson, in support of the previous bill, S. 1606. This testimony is to be found in the hearings of the Senate Committee on Education and Labor on pages 787–789. Therefore, the National Medical Association wishes to call the attention of the present Subcommittee on Health to this testimony in support for its present position in favor of S. 1320.

Furthermore, the National Medical Association cannot support the Taft health bill, S. 545, because of certain specific reasons which may be chiefly stated, as follows:

1. The bill with an allocation of $200,000,000 would not in anyway help to solve the health problems of the majority of the population of the United States and least of all that of the Negro. This amount would give medical care to only a small proportion of the population, possibly not more than 5 percent.

2. It places the receipt of medical care on a charity basis since individuals needing such services would have to prove that they were without means to pay for such care.

3. The Taft bill places the administration of the program in the hands of the States. Although this bill has a provision which states that there should be no discrimination on account of race, creed, or color, yet, because it places the administration of the program in the hands of the States, the National Medical Association is of the opinion that the practices which have been evolved in many Southern States whereby funds are not made available to Negroes in terms of their need would certainly obtain in the administration of the Taft bill. The experience in the expenditure of funds for education is a case of point. Southern States have for many years allocated to Negroes from one-half to one-sixth of the money spent for the education of white individuals.

4. The Taft bill virtually places the control of this program in the hands of the State and county medical societies. The Senators who formulated this bill should know that the American Medical Association which this year is celebrating its centenary has throughout its life span condoned a discriminatory policy against Negro physicians in the South. Negro physicians cannot belong to county or State medical societies in the South and thereby are barred from the American Medical Association. Therefore the opportunity for Negro physicians to participate in the planning of such programs and in the making of policies would be nil and no doubt the opportunities to give care to Negro patients would be markedly curtailed.

Thus, aside from the fact that the Taft bill would not help in the solution of the major health problems of the total population of this country, the National Medical Association is firmly opposed to it because it would provide the opportunities for discriminatory practices in health to continue.

The National Medical Health Association believes that the Federal Government has responsibility to see to it that in programs designed for the advancement of the health and welfare of citizens in this country, every effort should be made to curtail as much as possible, discriminatory practices.

PAUL B. CORNELY, M. D.

STATEMENT OF KATHERINE J. DENSFORD, R. N., PRESIDENT, AMERICAN NURSES' ASSOCIATION, NEW YORK, N. Y.

MAY 21, 1947.

The American Nurses' Association, of which I am the president, is the national membership organization of graduate registered professional nurses in this country, having an enrolled membership of over 176,000 members.

It has a constituent association in each of the 48 States, the District of Columbia, Puerto Rico, and Hawaii. These constituent units are composed of approximately 550 district nurses' associations. The association was organized in 1896 and has been functioning actively ever since that date for the following purposes, to the end that the public may receive better nursing care: "To promote the professional and educational advancement of nurses in every proper way; to elevate the standard of nursing education; to establish and maintain a code of ethics among nurses; * * * to disseminate information on the subject of nursing by publications in official periodicals or otherwise; to bring into communication with each other various nurses and associations * * * of nurses throughout the United States of America. * * *"[1]

The house of delegates of the American Nurses' Association on June 7, 1944, and again on September 25, 1946, adopted a recommendation favoring "the expansion of health insurance plans and providing for nursing service including nursing care in the home. It is believed that in addition to voluntary effort, governmental assistance is necessary for attaining adequate distribution of health services."[2]

On January 2, 1947, the Board of Directors of the American Nurses' Association, in considering S. 2143 of the Seventy-ninth Congress, second session (a bill dealing with the same subject matter as the present S. 545), adopted a recommendation that "(*a*) if a bill similar to S. 2143 be introduced, steps be taken to secure specific mention that nursing care in the home be included among services in State plans; and (*b*) that should the bill make specific mention of professional groups to be represented in the administration by advisory or technical committees, professional nurses be so included."

This recommendation was presented to the board of directors by the joint committee of the American Nurses' Association and the National Organization for Public Health Nursing on nursing in prepayment health plans. This committee had made a special study of the subject and had included the recommendation in its report dated January 1947. The American Nurses' Association has been informed that on January 23, 1947, the board of directors of the National Organization for Public Health Nursing likewise approved the recommendation of the joint committee.

---

[1] Certificate of incorporation of American Nurses' Association.

[2] American Journal of Nursing, July 1944, p. 629.

In order to carry out the principles approved by its house of delegates and its board of directors, the American Nurses' Association urges that S. 545 be amended in the following respects:

Page 2: Strike out line 14, and substitute therefor the following: "to make available medical, hospital, dental, home-nursing and public-health".

Page 4: Strike out line 25, and substitute therefor the following: "home-nursing care, hospital facilities, and all other health activities;".

Page 8: Strike out line 25, and substitute therefor the following: "Freedmen's Hospital; (3) the Office of Medical, Home-Nursing, and Hos-".

Page 10: Strike out line 5, and substitute therefor the following: "pediatrics and at least one of whom shall be a graduate registered professional nurse."

Page 14; Strike out line 25, and substitute therefor: "concerned with the provision of medical, nursing or hospital".

Page 16: Strike out line 18, and substitute therefor the following: "-oral health hospital, medical, and home-nursing services for families and".

Page 17: Strike out line 13, and substitute therefor the following: "of a State medical, nursing and hospital care advisory council."

Page 17: Strike out lines 17 and 18, and substitute therefor the following: "home-nursing or hospital services, including representatives of State medical associations, State nurses' associations, State hospital associations, volun-".

Page 18: Strike out line 6, and substitute therefor the following: "(a) hospital services, home-nursing services, surgical services, and".

Page 18: Strike out line 14, and substitute therefor the following: "provide medical or nursing care services in one or more of the".

Page 19: Strike out line 9, and substitute therefor the following: "ments to physicians and graduate registered professional nurses practicing in areas which, without".

Page 19: Strike out line 11, and substitute therefor the following: "income to attract a practicing physician and a graduate registered professional nurse."

Page 20: Strike out line 4, and substitute therefor the following: "medical, surgical, nursing, and hospital care, including that pro-".

Page 21: Strike out line 7, and substitute therefor the following: "nursing services, and periodic physical examinations as required by section".

Page 24: Strike out the sentence beginning on line 22 and ending on line 25, and substitute for said sentence the following: "Six of the eight appointed members shall be persons who are outstanding in fields pertaining to medical, nursing, and hospital care, at least four of whom shall be doctors of medicine and at least one of whom shall be a graduate registered professional nurse."

Page 25: Strike out line 2, and substitute therefor the following: "for medical, nursing and hospital care in urban or rural areas. Each".

Page 46: Strike out line 20, and substitute therefor the following: "pital, medical, dental, home-nursing, or any other services connected with".

No program of health care can be considered complete unless the program includes necessary nursing care. Any such program should contain provisions adequate to insure that the nursing services rendered will be of high professional quality.

The American Nurses' Association continues, as always, to be in favor of maintaining and improving the health service for all the people of the United States.

STATEMENT OF TAYLOR ELLIOTT, SECRETARY, WOOD RIVER CENTRAL LABOR UNION, WOOD RIVER, ILL.

Members of the Central Labor Union of Wood River, Ill. (A. F. of L.), have been reading with interest the reports and discussions coming from the Senate Committee on Education and Labor relative to the National Health Act (S. 1320 and S. 545). Perhaps we cannot be blamed too strongly for throwing out our chests and saying, "I told you so," when we read of this bill. We make this statement because it has now been something like 6 years since this organization started a local health program directed toward aiding its members and others in the community. Foremost on the program was a badly needed hospital. The war held up the plans on this but they are now going forward as scheduled.

The important thing, it seems, is how we became aware of the need of our members and others in the community for medical attention on such a large scale before it became a national issue. This was due largely to preferential-hiring clauses in some of our labor contracts and the large number of persons rejected because of physical defects which was brought to our attention because of these clauses. At first, this only aroused our ire, we thinking the companies were definitely discriminating against those whom we offered for employment. However, a later and more complete check convinced us that, while the companies' examinations undoubtedly were too rigid, that part of the "turn downs" were due to physical defects that could and should have been corrected long ago. Some few years later, the United States Government discovered the very thing we had known for years, but it was not discovered until they started examination under the Selective Service Act.

The peculiar thing about organized labor is the people who put up the greatest fight to obtain an objective never reap the greatest benefit. We have long been accustomed to carrying along a certain percentage of people who can legitimately be called hitchhikers. They go along for the ride but contribute nothing to the work or expense of making that ride possible. We have others who are less fortunate and could not help themselves if they chose. The first-mentioned could help themselves, but won't; the second would help themselves, but can't. These two groups of people are benefited most by, and put forth the least effort for social and industrial legislation. We do not rue these people being benefited by our efforts, but are rather proud of it. Our only purpose in mentioning it is to draw attention to the fact that when organized labor speaks in behalf of certain legislation they really speak for all workers. The unorganized worker has no effective means by which to speak. He knows that when we ride he rides with us.

The community in which we live is but half day's drive from the share-cropper district of the South, and almost everyone in this locality has witnessed their plight by "eye-see, and not by hear-say." The tenant farmers and migratory workers of this country are, as a class, but one step removed from the slavery that prevailed before the Civil War. In many respects, the freedom for them to starve or to die for want of adequate medical care is worse than the chains of slavery that did at least believe that the slaves should be properly clothed, fed, and be given decent medical attention to increase their efficiency. It is for those people who are not members of organized labor that we most beseech the passage of S. 1320.

Naturally, there will be many reactionary groups opposing this legislation. There always has been and there always will be. We have dealt with these people ourselves and know how they think. This same group opposed the Wagner Act. They opposed the social-security laws, the Norris-LaGuardia Act, and all others of benefit to the working plan. We must only look back a few years, and within the memory of many of us, to find some people of the same turn of mind locking their employees in their business establishment to prevent them any freedom at all. If these same people had possessed enough political guns the same conditions as to safety and industrial legislation would exist today. One such condition as referred to above resulted in the tragic Triangle Waist Co. fire of May 1911 when nearly 150 workers were trapped behind locked doors and burned to death.

We see little difference in killing a man by that method or having him die because of inadequate medical attention or because he has not sufficient funds to pay for that attention. The results are the same. In either case, he is dead. The only difference we are able to see is that in the case of the fire, these people died almost instantly and perhaps in many of the other cases they just sort of ooze out. We would say many of the people who are responsible for killing of worthy social legislation have such a versatile mind that they grab their dividend check with either hand.

The Wood River Central Labor Union of Wood River, Ill., wishes to vote "Yes" on S. 1320. We regard this as essential social legislation. If you ask us just how essential, we'll say just about as essential as Amos was to Andy.

PART 2. WHY WE PREFER S. 1320 TO S. 545

While registering a vote for S. 1320 the Central Labor Union of Wood River, Ill., wishes to go on record as opposing the Taft bill, S. 545. After reading this bill we feel that it is characteristic of our present Congress. It seems to be a bill to create the impression that something is about to be done for the common people, but when placed into action the results will not be there. This is a hodgepodge bill something after the order of the Taft-Hartley bill recently enacted into law.

This type of legislation no longer fools the American people. They have swallowed the hook too often. Now the authors of this bill have attempted to bait the hook again. This bill makes it necessary for a large part of our population to rely upon charity to meet their medical needs. Charity seems to be an "old American custom." Not only in the medical field but in other fields. Yes; we will admit that Columbus probably sprung the idea on the Indians when he first landed, and it has caught the fancy of a certain class of our people ever since—the class that doesn't care to help anyone but themselves. We don't agree with that custom.

We in this community saw from a short distance how charity works in such cases. This happened during the dark days of the Hoover administration. A manufacturer in the vicinity had imported a large number of people through newspaper advertisements throughout the Southern States. When the depression hit, these people were laid off in droves and thrown upon the mercy of the public—there being no other means provided for taking care of them at the time. The net result was that the poor people in the community took care of the poorer and the wealthy took care of themselves. This was a simple means of making the rich richer and the poor poorer.

The man who was responsible for importing these people from the South did nothing to aid them in their time of need, yet it was a well-known fact that his wealth was so great that he could have taken care of all the charity cases in the entire community and never even known he was doing it. What happened in the case just cited would only be repeated under bill S. 545.

This council feels that Congress must surely know that with the present cost of living at its dizzy height that the average workingman cannot afford a sick spell. Physicians in this locality have raised their fees as much as 200 percent recently and in all cases 50 percent or more. The American Medical Association members in this one locality will admit that most people with incomes of under $3,000 per year do not pay for all of their medical care. The Bureau of Labor Statistics reports that nearly 70 percent of our population comes in that group.

Are we to admit as a Nation that 70 percent of our population must either depend on the other 30 percent to help provide them with medical care or they must do without? We at Wood River, Ill., aren't willing to admit that. That is the reason the ground has already been purchased and the plans drawn for our new hospital, a project started by our council. We are miles ahead of our Government in the race to provide health for our community.

As was stated earlier in this article, we at Wood River, Ill., probably could take care of ourselves. We have done so to such an extent that we are ahead of both our National Government and State. In fact, when the election was held to float bonds for the hospital mentioned it carried more than 19 to 1. We know, however, that there are in this Nation millions less fortunate than we. Therefore, we would like to have a real health bill for these people, one that doesn't make a person feel as if he were begging. Such a bill is S. 1320.

On the other hand, S. 545 will not fill the want of a great majority of our people. We are certain of that. Neither will any other bill that depends on charity. Our vote is for S. 1320 and against S. 545.

TAYLOR ELLIOTT, *Secretary.*

STATEMENT OF MRS. JOSEPHINE ANDERSON EVANS, NATIONAL NONPARTISAN COUNCIL OF ALPHA KAPPA ALPHA SORORITY, WASHINGTON, D. C.

The nonpartisan council on public affairs of the Alpha Kappa Alpha Sorority is an organization composed of 10,000 Negro college women. There are 186 chapters throughout 46 States. The majority of the members of our sorority are professional women and are active in civic and community affairs.

We are opposed to the Taft health bill, S. 545.

The American peoples are not getting the medical care that they need. Statistics show that thousands die from the lack of medical care. The Nation is crying for help. Because of economic enslavement colored Americans are among those in most desperate need for medical assistance.

S. 545 is not designed to meet the need for many reasons. It prefers charity by requiring participants to appear before local boards and establishing their indigence. We may be wrong but we do not interpret the people's cry to be one for a "hand-out." There are millions of Americans who are self-respecting but who are thrown into financial dilemma when unexpected illness attacks. It has been appropriately pointed out that illness is not a budgetable expense. It gives no warning and it respects no financial barriers. The American peoples want to pay their own way. That is the American way, but is not the way of S. 545.

Further, even though persons may be willing to apply for charity as provided by S. 545 only those persons whom the State or local boards chose to certify would be eligible to participate. To those who would impress us with the desirability of this measure for Negroes inasmuch as a large segment of the colored population falls within the indigent groups, we turn a deaf ear. We know that such is not the truth since determination of eligibility is left to State and local groups. The Taft bill's provision that "there shall be no discrimination on account of race, creed, or color" is obviously inconsistent in reality with the additional provision that "administration of the program would be in the hands of the States." To what degree would the colored population of Mississippi, South Carolina, Alabama, etc., benefit from a program so administered? Indeed, Dr. Shoulders of the American Medical Association, speaking for that body, said that the presence of diverse racial elements posed a serious obstacle to any national health-insurance bill in this country. This should not be so if those legislating for the welfare of all Americans and those dedicated to serve the health of all human beings are sincere in their respective duties. The Taft bill expressly recognizes this undemocratic and irrational view of the AMA. In deference to this group, the Taft bill proposes to—in fact it does—incorporate segregation and discrimination into a national program for the welfare of all Americans.

Further, it cannot be denied that national, State, and local administrative bodies would be practically controlled by the State and county medical societies and the American Medical Association. You know, of course, that Negro physicians are not admitted to these medical societies, with perhaps few exceptions. It follows, therefore, that Negro physicians participating in the Taft health program will be negligible in number if at all.

We do not subscribe to the result of the Taft bill whereby the national advisory councils would be dominated by professional people without any representatives from the ranks of the beneficiaries themselves irrespective of the absence of colored professional persons on the council. The certainty that there will be a total absence of colored physicians from southern boards couples with the fact that the southern colored and white will not be afforded even a minimum representation as consumers, serves further to justify our opposition to S. 545.

There are other objections that could be made to the Taft health measure. We consider these to be among the most glaring.

No, gentlemen; America is not asking for this measure. Some of her doctors may be but they are in the minority roll call as compared against American consumers of health services. We feel S. 545 to be an ill-conceived measure that is not even acceptable as an honest compromise for the welfare of America's greatest national resource—its citizens.

* * * * * * *

We heartily endorse and seriously urge that you report this measure out as the most feasible and desirable health legislation for the people of America.

As Americans and as Negroes we keenly appreciate the need for S. 1320. We want a bill that will serve to help us raise each individual's standard of health and one which administers democratically, adequately, and humanely to the health welfare of Americans.

Briefly, here are some of the reasons why we support this bill: The tenor is such that each consumer helps to pay his own way, which does not belittle his respect for himself. About 135,000,000 American people would be included in the plan, or approximately 85 percent of the population. Consumers will be adequately represented as such on State and local administrative boards. Adequate and unequivocal protection against discrimination in the capacity of consumer or physicians, dentist, or nurse is assured. Doctors, especially colored, will be free to establish practice in the South (miserably in need of them) with the certainty of a reliable income.

Health statistics among all Americans are appalling, but those figures are even more startling when broken down according to race. Consider the following, which compares the health and life expectancy of Negroes and whites:

GENERAL

1. General Negro mortality rate is 30 to 40 percent higher than rate for white persons.
2. Between ages of 20 and 24, three times as many Negro as white women die.
3. Negro life expectancy is 10 to 12 years shorter than that of other whole group.

(Above figures from Racial Aspects of Reconversion, memorandum to the President of the United States, National Urban League, New York City, 1945.)

4. Life expectancy: Rate per 1,000, general population in United States, 1944.

	White		Negro		Total persons
	Male	Female	Male	Female	
Birth	63.55	68.95	55.30	58.99	65.12
Age 30	39.22	43.06	33.66	36.43	40.42
Age 40	30.39	33.97	26.26	28.92	31.63

From Statistical Bulletin, Metropolitan Life Insurance Co., May 1946, vol. 27, No. 5. The table is computed on basis of unpublished data furnished by the U. S. Census Bureau.

SPECIFIC DISEASES

1. In 1943, proportionately three times as many Negro males and four times as many Negro females as white males and females, respectively, died from tuberculosis, and in certain cities and age groups, the disproportion reached levels of 8 to 1.
2. In spite of sulfa drugs, pneumonia and influenza still kill proportionately twice as many Negroes as whites.
3. Higher infant and maternal mortality: Twice as many Negro mothers and one and one-half times as many Negro infants as white mothers and infants die yearly in this country.
4. Pellagra: Four times as many Negro males and six times as many females die in comparison to white males and females.

FACILITIES

Number of M. D.'s: Number of Negro M. D.'s during past 10 years decreased 5 percent in the Nation as a whole and 12 percent in South, while total number of M. D.'s in Nation increased. The South with over 10,000,000 Negroes has little over 2,000 Negro M. D.'s.

Number of dentists: Approximately 1,700 Negro dentists serving 13,000,000 Negroes in United States.

Number of public health nurses: As of January 1942 there were 917 Negro public nurses. Approximately 460 were employed in 17 Southern States.

Number of hospital beds: To provide care for 12,000,000 Negroes in United States, 550 governmentally owned hospitals admit Negro patients and 110 hospitals are specifically set aside. In all these hospitals there are 4,192 beds available for Negroes, a ratio of 0.03 per thousand.

From study by E. R. Carney, president of National Hospital Association, quoted by Dr. T. R. Ponton, editor, Hospital Management, Consideration of the Factors Which Influence Hospital Service, Hospital Management, July 1940, page 52.

Excerpts from table 2 (p. 15), Hospital Service for Negroes, T. R. Ponton, M. D., Hospital Management, indicating estimated number of beds for Negroes in States in which Negroes are segregated:

State:	Beds per 1,000 for Negroes
Alabama	1.2
Arkansas	.9
Delaware	3.6
District of Columbia	6.4
Florida	1.7
Georgia	1.0
Illinois (Chicago)	1.6
Illinois (remainder)	8.5
Indiana	2.9
Kentucky	2.5
Louisiana	1.2
Maryland	3.1
Mississippi	.5
Missouri	5.2
North Carolina	1.4
Oklahoma	1.8
South Carolina	.9
Tennessee	1.4
Texas	1.3
Virginia	1.4
West Virginia	2.8

These figures do not indicate any racial propensity toward ill health; rather, they directly reflect the social and personal ravages of inadequate medical attention which in turn reflects the involuntary economic servitude of the Negro. He simply cannot afford medical care as offered today. He can, however—and thousands similarly situated—begin to repair his health, the health of the South, and the health of the Nation through S. 1320. For although he will miss the 1½ percent pay-roll tax by him, he will not miss it nearly as acutely as a lump sum from his meager wages for medical care. More likely than not be will not even have a lump sum to use for the luxury of medical care.

The underlying principle of S. 1320 is a logical, feasible, and democratic one—pay as you go. It is the principle upon which our system of taxation, social security, and workman's compensation is based. S. 1320 will initiate a health program of tangible and substantial benefit to the millions who need it. We feel that it is an imperative measure and the only one which can help the Negro to help himself. Because S. 1320 is comprehensive (embracing diagnostic, preventive, and curative medical care), we believe that wtihin 10 years the statistical picture of the Nation's health will reveal tremendous improvement from the date of its enactment.

STATEMENT OF DR. JOSEPH H. HOWARD, BRIDGEPORT, CONN.

My name is Dr. Joseph H. Howard, a practicing physician in Bridgeport, Conn. I am appearing in favor of S. 545.

It would seem to me that this is the logical approach to a problem which is not too difficult to solve. There has been considerable agitation in the past few years for the passage of some form of compulsory sickness insurance. The general impression among the people of the United States is against the control of medical practice by the National Government. This is borne out by a survey conducted by the Opinion Research Corp. of Princeton, N. J. Answering to the questions, "Have you heard of the term 'socialized medicine'?" and "Are you for or against socialized medicine?" the answers were: Have not heard, 45 percent; have heard, 55 percent; for, 13 percent; against, 34 percent; don't know, 8 percent.

Answering to the question, "Do you think it would be good or bad for the country if the medical profession were controlled by the National Government?" the replies were: Good for country, 23 percent; bad for country, 65 percent; no opinion, 12 percent. The question was asked: "Are you familiar with the Wagner-Murray-Dingell bill which proposes to set up a Federal medical-care program to be paid for out of increased social-security pay-roll deductions?" The responses were: "Yes, am familiar," 91 percent; "No, am not familiar," 9 percent, indicating that the people of this country have a knowledge of legislation before Congress.

Following this the question was asked: "From the standpoint of the general public, do you think the passage of this bill or some similar bill would be a good thing or a bad thing?" The responses of the 91 out of every 100 who were familiar with these proposals were:

	Percent
Good thing for public	11
Bad thing	78
Some ways good, some bad	10
No opinion	1

It would appear, therefore, that if we have gaps in our medical care, some method must be utilized to overcome such difficulties on a different basis. S. 545 seems to meet that situation without encroaching upon the present type of medical practice and yet takes care of the problem of the low-income group who at the present time may need some help.

The bill specifies that the health functions of the Federal Government should be in a single agency, a step to overcome overlapping of these agencies with the saving of efficiency and money. It also proposes to expand the activities of the Public Health Service and to encourage medical and dental research in the National Institute of Health and in the several States through grants-in-aid; to construct a National Institue of Health and Dental Research Institute and for the deduction from the pay rolls of Federal employees for the payment into voluntary plans of sickness insurance and to give some aid, both medical and dental, to the low-income groups. Physical examination of school children as specified in the bill is most essential to keep these children in good health and to determine early any physical defects. The subsidy to rural physicians to encourage young men to practice in sparsely settled areas is most commendable and the dental health service will do much to meet the needs, especially in the children and among many of the adults.

It might be well for us to consider what are some of our problems in this country. Have we come to such a stage in medical care that conditions have reached a critical point? Statistics do not bear that out. Dr. Haven Emerson, professor emeritus of public health administration at Columbia University, has this to say: "We can properly note that every index of health, of relative freedom from preventable disease, and of longevity reveals a state of affairs in the United States superior to that of any other aggregation of people or of races elsewhere under single or multiple governments."

The draft statistics of the recent war have often been quoted at length to show the deplorable condition of health that exists among the young people of our country. It is stated that four and a half million boys were rejected because of physical defects, many of which were due to improper care. This has been broken down several times to show that of this group over 700,000 were rejected for mental ailments, 562,000 for mental deficiencies—idiots, imbeciles, and morons—320,000 rejected for muscular and skeletal defects such as clubfoot, withered arm, congenital dislocation, and the like; 280,000 were rejected because of syphilis. It is hardly necessary to go into the details of these various groups in order to show how little difference medical care would have had upon these defects, since this has been given to you before by previous speakers.

It might be well, however, to compare the draft statistics of this country with Germany, where a system of state medicine has been in effect for many years, to see what effect their program has had upon the youth of that country. The information I am about to give you is based on three available documents: (*a*) Regulations for Medical Examination in the Military Forces. These regulations were approved by General Von Blomberg on March 24, 1936; (*b*) Physical Standards for German Military Service, and (*c*) Muster and Recruitment Decree of March 21, 1936. The comparison, therefore, is between the fitness of the German Army when they first entered the war as compared with the American Army at the time when we first saw service.

The American classification in the early days consisted of the categories I–A, I–B, and IV. The German grouping was somewhat finer; Fit–1, Fit–2, Conditionally Fit, Temporary Unfit, Limited Fitness, Unfit for Military Service, and Fully Unfit. In comparing the American Army with the German, it is important to note that only the American men meeting the requirements of 1–A were actually inducted while all those of I–B or class IV were not called to service. In the German Army those who could not meet the requirements of the American class I–A were accepted for service in one of the other classes. The Germans were utilizing every young man of military age who was physically or mentally able to do any kind of military service. The American attitude was different in that we rejected all young men of military age who could not meet the high physical and mental specifications of class I–A.

During this period the percentage of rejections in the German Army were 16.94 percent, whereas in the American Army it was 50.1 percent. Poor teeth or absence of teeth accounted for 10.5 percent of the rejections of American boys. It was the most frequent reason for rejection in the American Army. If we adopted the German standards, the number of rejections would be almost nil. For example, an American boy who had less than three pairs of occluding incisors or canine teeth or fewer than three pairs of opposing premolars or molars was unfit for military service. The Germans, however, accepted men with no teeth or with dental plates that fit firmly and also accepted those with crowns or bridges that were serviceable.

The only men who were rejected by the Germany Army were those who had such extensive disease of the jaw that it interfered with speech, mastication, or general nutrition.

The second most common cause for rejection among the American soldiers by local industion boards was defective vision or disease of the eyes. The requirements were that a man's vision must be 20/40 in each eye or must have not less than 20/100 in each eye and be correctable with glasses to at least 20/40. The German Army accepted boys with much poorer vision for Fit–1 and in those cases with marked defects in vision, they were accepted into Fit–2 or Conditionally Fit and given some particular type of duty. The 6.9 percent of American draftees who were rejected because of visual defects would have been much less if we had followed the German standards.

Regarding cardiovascular diseases, the American examiners were most careful to be certain that the heart and vascular system of these draftees would stand the strain of Army life. Another factor which came into this decision was the fact that many of these boys would demand a pension because of disability incurred during military service. However, the Germans disregarded this and gave little attention to some of these cardiovascular diseases, not worrying about future compensation.

In the early days of the war the Germans did not even take blood pressure readings on draftees, whereas in the American Army a pressure of 150 systolic over 90 diastolic was sufficient for rejection. An unusually rapid pulse was also a reason for rejection in the American Army whereas the Germans make no mention of that.

The American Army rejected those cases of spinal curvature which were acceptable in the Germany Army. No man was accepted into the service in this country who was not able to wear a regulation military shoe, whereas in the German Army those with club feet were acceptable. Flat feet were not accepted in our Army but were with the Germans.

All cases of hernia were rejected in the American Army whereas the Germans accepted these individuals if the hernia could be repaired by operation or controlled by the use of a truss or bandage.

We have noted in the statistics that 280,000 were rejected in the American Army because of venereal diseases. The Germans accepted all of these cases and treated those that required it. The only cases they did reject were cases of syphilis which involved some of the vital organs such as the brain, spinal cord, or blood vessels, or gonorrheal arthritis.

Defects and diseases of the genito-urinary tract were rejected in the American Army but were given limited service in Germany. Defects of the testes, large hydrocele, large varicocele, benign tumors of the testes, and undescended testicles lying in the inguinal canal, although rejected by the American examiners, were acceptable to the Germans for at least limited service.

Those with mental and nervous diseases were definitely rejected in our Army whereas in Germany the neurotics, morons, chronic alcoholics, drug addicts, and even psychopaths, unless seriously affected, were given limited service. The only persons subject to rejection were those serious psychopaths, idiots, and imbeciles.

The American examiners were cautious in examining the ears. The standard was that the man should have no less than half of the normal efficiency in each ear. Perforated eardrums and chronic infections in the ear were rejected. The Germans, however, accepted drum perforations and also middle-ear infections which did not impair to any marked degree.

Diseases of the nose and throat were carefully screened by the American examiners but all of these were accepted by the Germans except those severe cases in which the defect caused some disturbance in speech or inability to swallow properly. Every young man who was inducted into the service in America had a chest X-ray to determine whether or not tuberculosis was present. Small, well-healed calcified lesions was not a reason for rejection. In the German Army only those cases of progressive, contagious, pulmonary tuberculosis were rejected for military service. Other diseases of the chest, such as chronic bronchitis and emphysema, were inducted into the German Army and were rejected by the Americans. There was no routine X-ray of these German soldiers to determine whether or not they had tuberculosis before entering the service, and instructions to the examiners were simply to determine if clinical signs existed and were suspicious that tuberculosis existed an X-ray should be taken.

Even those cases with diabetes mellitus, diabetes insipidus, and some cases of epilepsy were given limited service in the German Army. Asthma was acceptable as conditionally fit or limited fit. Gastric or duodenal ulcers were totally rejected by the American examiners but were given limited service in the German Army.

Because of these liberal regulations, in 1935 the Germans found that 77 percent of their inductees came into fit—1 and 2. With the addition of the conditionally fit, this percentage came to 83 and the temporarily unfit brought the figure to 89 percent. An examination of the rate of rejection in the American Army shows that if we had adhered to the regulations of the German Army our rate of acceptance would be from 50 to 78 percent. We must also take into consideration the relatively high percentage of rejections among the Negroes in the southern section of our country, a problem which the Germans did not have. Another factor which is of great importance in analyzing these figure is that the American examinees ranged between the ages of 21 to 35. The German figures of 1935 are based only on young Germans who had just reached the military age of 21. When we divide the various age groups of the American draftees, we find a considerable difference in the percentage of rejections. For example, in the age group of 31 to 35, 26 percent were rejected, whereas in the 26 to 30 age group, 18.2 were rejected, while only 12.9 percent of those selectees under the age of 25 were placed in either class I–B or IV. The final figure, therefore, of American boys under the age of 25 using the German standards would be 17.7 percent, which means that about 82 percent of the American boys between the ages of 21 and 25 would be acceptable under the German standards. This corresponds rather closely to the German figure of somewhere between 77 and 82 percent.

Statistics of all types showing the condition of health among the American people are sometimes most misleading. A year or so ago a Philadelphia newspaper presented headlines stating "79 Percent of Pupils Need Health Care; the Majority of Children Declared to Have Physical Defects." This was a startling disclosure which would indicate that only 21 percent of those children were normal. However, an analysis of these figures showed that decayed teeth accounted for 27 percent of these defects. There is no known way at present of preventing tooth decay. Ten percent of these children showed malnutrition. This, of course, was not entirely a medical problem but a question of home care and proper feeding. Defective vision, poor posture, and flat feet accounted for a large group, and here again medical care would have very little effect.

The span of life of our people has doubled, the life expectancy of man now being over 65 years. There has been a great reduction among the deaths in children. The infant death rate has been cut in half in 15 years and deaths from diphtheria, whooping cough, scarlet fever, and measles have been reduced to almost one-tenth the 1929 rate. The Institute of Life Insurance of New York 2 years ago commented on the marked reduction in mortality among the people in this country and reported that about 75 percent of all the savings of life since 1929 have been accounted for by just the reduction in death rates from tuberculosis, typhoid fever, influenza, and pneumonia. The ravages of these four diseases alone have been so checked by the intensive efforts of recent years that in 1945 there were at least 75,000 fewer deaths among policyholders than there were in 1929.

So frequently it has been said that the saving of lives has been due to the public-health measures and the development of newer drugs by the laboratory workers. The discovery of the sulfa drugs and penicillin has gone a long way to reduce the death rate in various infections but this would not have been possible without the proper clinical application of these drugs by the family doctor, the careful diagnosis to determine whether or not the drug was indicated, the cautious application of the drug with daily blood studies—all are essential in the proper treatment of these cases; and that duty falls upon the doctor.

There are regional differences which affect this whole problem of health—population, climate, economic conditions, social problems, and so forth.

Heart disease ranges highest in nine States, six of which are in New England, the reason being that people live longer in New England than elsewhere. Tuberculosis occurs in 10 leading States, 8 of which are in the South. Arizona, Colorado, and New Mexico have a higher rate because of the tuberculosis sanatoria. In Tennessee and Kentucky the rate is four times that of Utah, Wyoming, and Nebraska. In cancer six of the seven States with the highest rate are in New England due to the age group in this area. Influenza and pneumonia are highest in the South. In Florida 30 percent of the rural school children are infected with hookworm and 42 percent of the rural school children in Florida are anemic.

In Alabama, Mississippi, and the Carolinas there is only 1 physician per 1,400 population. In Alabama, Georgia, and Kentucky there is 1 hospital bed for every 600 people. In Rhode Island, California, and Massachusetts there are three times as many. Mississippi and Arkansas have no sewage system for 70 percent of the population. All of these factors enter into the question of morbidity and mortality. Improvement in the standard of living, increasing educational facilities, and offering greater economic opportunities to the people in the South will go a long way toward reducing their death rate.

During the war the Metropolitan Life Insurance Co. showed the 1945 death rate of 7.4 per thousand or 2.2 percent lower than in 1944 even with the shortage of doctors, the increased amount of work by the people, deficient diet and fatigue. Even more striking has been the reduction in maternal mortality. There was a rapid and continual decline in the number of deaths among these women in practically every State in the United States. The death rate in Connecticut for 1946 was 0.9 per thousand live births. This record has never been equaled anywhere in the world. From 1900 to 1940 the general death rate per thousand population of the United States decreased 60 percent. Since 1900 the number of days lost per year by the average worker through illness dropped from 28 to 8.

At birth the average white child can be expected to live 65 years; Negroes, 53 to 55 years. This life span is 16 years longer than in 1900. In Sweden it is 63; in England, 59; in France, 54; in Chile, 41; in British India, 27.

Three years ago I discussed absenteeism with the chief physician of one of the largest factories in Connecticut, an organization that had plants scattered throughout the United States engaged in war work. I inquired as to the cause of absenteeism and was informed that 50 percent was due to upper respiratory infections during the winter months and even during the summer it accounted for 35 percent. These colds were not preventable and there was no specific cure. Any change in medical practice would have no effect upon these individuals.

These statistics and many others indicate that the United States is the healthiest large nation in the world. The problem, therefore, appears to be relief to those people who find it a hardship in paying hospital and doctors' bills, and the proposal as exemplified in S. 545 answers to a large extent that problem. There are other helpful means for overcoming this, one of which is the Blue Cross and the other prepayment medical plans in the various States. The rapid growth of the Blue Cross since 1933, when there were two plans to the present time, when there are 25,000,000 subscribers is encouraging and indicates that the public prefers that type of coverage for hospital expenses. The growth of prepayment plans has been slower because it is younger and it is necessary to progress cautiously, learning by experience how much coverage it is possible to give without adding too much of an expense on the subscriber. At the present time enrollment in medical service plans throughout the country amounts to 4,779,989. These prepayment plans vary in different States and different sections, which must of necessity be so since there is no over-all pattern for health for a country as large as the United States.

On the question asked by the Opinion Research Corp., "What especially do you think might be done to make it easier for people to pay doctor or hospital bills?" 44 percent specified prepaid medical care or hospitalization or insurance of some kind; only 8 percent approved compulsory Government insurance deducted from wages so everyone will be covered.

Under the bill S. 545 dental care would be given to the low-income group. Complete dental care for all of the people of the country is not possible. There are just not enough dentists to do all that work, but the early care of children's teeth will pay dividends for the older individuals as the child progresses.

People are not concerned with ordinary medical bills. The thing that disturbs them most are the catastrophic illnesses. To the question of the Opinion Research Corp., "Do you think that an easier method of payment is needed to meet ordinary doctor bills, or just to take care of serious emergency illnesses?" the answers recorded were: Ordinary bills, 6 percent; serious illnesses, 36 percent; both, 23 percent; no opinion, 5 percent.

So often it is stated that in the European countries before the present compulsory system was in vogue voluntary plans were tried but failed. We should not be discouragéd with the failure of voluntary plans in Europe. Democracy has failed in Europe but we have made it a success. The insurance plans in England have changed from time to time not because they were satisfactory but because they have been failures and they go deeper and deeper, hoping to arrive at some solution for their problem. Because their system was a failure, they try another.

According to Health and Accident Underwriters Conference, more than 40,000,000 people are covered under some form of accident and health policies. This is a fivefold increase over 1934. In the State of Washington in 1935, 45.3 percent of the population were covered by prepayment plans. It is argued that those in the lower income group cannot afford hospital and medical insurance. However, they seem to be able to pay it off in installments after the illness is over. The committee on the cost of medical care found in a study of 90,000 families that when a family with less than $2,000 income had bills of $500 to $1,000, the city families paid off 75 percent of their charges within a year. The town families paid 89 percent and the country families 94 percent. Bills of this size do not often recur in families of low income level and the ability of these families to pay such a bill is quite striking.

The present economic condition of this country is emphasized by the report of the Research Council for Economic Security which shows that the American people have more than $300,000,000,000 in banks, investments, and insurance. Cash deposits and Government bonds amount to $175,000,000,000.

The public are becoming rapidly informed as to the value of hospitalization plans and prepayment plans, and it is merely a question of education and to encourage them to budget for illness as they do for other things. Rarely would a man attempt to drive an automobile without fire and theft insurance on his car, or liability.

Title II, section 203, reads:

"Section 314 of the Public Health Service Act is amended by adding a new subsection following subsection (b), as follows:

" '(c) To enable the Surgeon General to carry out the purposes of section 301 with respect to developing more effective measures for the prevention and control of cancer and to assist through grants and as otherwise provided in this section, States, counties, health districts, and other political subdivisions of the State in establishing and maintaining adequate measures for the prevention and control of such disease.' "

For this purpose there is appropriated $10,000,000 for each fiscal year. Some criticism has been made of this comparatively small sum to be used in such a vast undertaking. However, apparently it is not the intent that $10,000,000 per year would cover the entire program of research for the prevention and control of cancer, but it will go a long way toward developing plans in those States where it is most needed to reduce cancer by education of the public, by the establishment of detection clinics, and by the encouraging of hospitals to develop cancer clinics. In order to emphasize how much can be done in this field and what the results would be in the reduction of cancer, I should like to quote some figures from the State of Connecticut where a very active cancer program has been in effect for the past several years.

During the year 1945 in the State of Connecticut there was a decrease in the number of cancer deaths for the first time. This was due to this very effective program which has been carried on for some time. The plan is under the supervision of the State department of health, the Connecticut State Medical Society and the Connecticut Cancer Society. During the fiscal year approximately $300,000 was spent on the entire project. The results of this intensive effort to reduce the number of cancer deaths in the State has resulted in the following:

There are at present 11,767 living, traced individuals who have been treated for cancer in Connecticut hospitals since January 1935. The population of Connecticut is 1,781,514. This means that the actual number of individuals living in the population who have had cancer is 666 out of every 100,000 people in the State. This also means that there are 4.2 individuals who have had cancer and are living, for every death from cancer over these 11 years of experience. It is possible in Connecticut to trace all of these cancer cases since a registry is kept in the State department of health and its coverage is 95.7 percent of all general hospitals.

The usual length of time after which recurrences of cancer occurs is approximately 5 years. There are 3,051 individuals who have passed this period in Connecticut and are living from 5 to 12 years after treatment. This means that 3,051 of 1,781,514 people living in Connecticut, or 171.3 of every 100,000, have had cancer, been given treatment, and have been either cured or have survived far beyond the usual span of life of cancer patients; 1,133, or 127 out of every 100,000 males in the population are included in this group. The female survivors amounted to 1,918, or 215 out of every 100,000 females in the population.

Since skin cancer is diagnosed earlier than most other types and is cured more easily than others, one might assume that included in this large salvage there would be a great number of skin cancers. However, that is not true, since less than one out of four were skin cancers and one in eight of the total survivors also had cancer of the skin.

Due to the improvement in the detection and the education of the public, the number of cases of cancer admitted to the hospitals in Connecticut increased from 2,160 in 1935 to 4,168 in 1945. The number of individuals coming to immediate treatment has more than tripled, and the number of individuals who were delayed because of inadequate medical advice in 1946 is less than one-fourth the number so delayed in 1938. It is interesting to note the reasons for the delay in reporting for a diagnosis of cancer from the following table.

Reasons for delay

	1938		1946	
	Cases	Percent	Cases	Percent
No delay	106	10.6	382	38.2
Fear	20	2.0	17	1.7
Economics	15	1.5	0	0.0
Inadequate medical advice	121	12.1	29	2.9
Cults	2	.2	5	.5
Negligence or ignorance	338	33.8	265	26.5
Not stated	398	39.8	302	30.2
Total	1,000	100.0	1,000	100.0

In 1938 2 percent were not examined because of fear. In 1946 this dropped to 1.7 percent. In 1938, due to economic conditions, 1.5 percent were slow in applying for diagnosis and treatment whereas in 1946 among the group surveyed there were no patients who felt that they did not apply for examination because of their economic status. An interesting point in this survey is that in 1946 three times as many individuals sought medical advice and were treated without delay as there were in 1938. In 1938 there were 121 individuals or 12.1 percent of the total 1,000 cases studied who delayed on the advice of physicians, or were not properly diagnosed when they presented themselves for examination. In 1946 there were only 29 or 2.9 percent of the thousand cases studied who delayed for this reason. There are some hopeful signs also in the reduction of those cases due to negligence or ignorance who came late for diagnosis and treatment. The education of the laity, therefore, is most important and this is basic in the Connecticut program.

Two of the most virulent types of cancer that occur and in which the early diagnosis is so important are those of the breast and the mouth. In Connecticut in 1935, 28.3 percent were alive after 5 years, whereas in 1941 there were 42.8 percent still alive and there is a gradual improvement in the number of these cases each year. The same improvement occurred in cancer of the mouth where in 1935 16.5 percent were alive after 5 years and in 1941 it increased to 35.5 percent.

The interest in the cancer program in Connecticut has been so great that all but 13 States have applied and received information regarding our plan, and in these States they have already initiated a similar plan or are in the process of doing so. It is hoped, therefore, that if this continues to spread throughout the United States that we may see within the next few years a definite reduction in the cancer deaths. It can be readily seen, therefore, that an appropriation of $10,000,000 per year would go far in meeting the demands of such a program as outlined in the State of Connecticut.

The experience in Rhode Island has not been very encouraging. A bill introduced in 1942 became the first State compulsory cash-sickness compensation law in the Nation. That law became effective May 10, 1942. The Rhode Island law as originally enacted limited the amount which could be used for administering the cash-sickness program to 1 percent of the contribution collected. Later that was increased to 3 percent. The cost of administration rose so rapidly and the reserve fund depreciated to such a degree that it was necessary to make certain readjustments in the law and several amendments were passed in 1946.

Malingering existed to a great extent and the doctors had to appeal for some help due to the fact that patients were appearing in the doctor's offices asking for certificates which would allow them to collect unemployment compensation and cash-sickness benefits. In order, therefore, to bolster the plan, several amendments were adopted which reduced the periods for pregnancy from 20 to 15 weeks maximum and eligibility after cessation of employment was reduced from 2 years to 6 months. Those entitled to workmen's compensation as well as cash-sickness benefits can receive not in excess of 90 percent of the average weekly wage. An advisory committee of seven members was created. One-half of 1 percent of the State unemployment tax borne by the workers was diverted from the unemployment compensation to the cash-sickness fund for a 2-year period to raise the revenue 50 percent. These changes were necessary since under the old law it was possible for a man to collect more while he was sick than while at work. A pregnant woman received the maximum amount of benefits payable under the act. This is an example of the abuses that can arise from a system of this type.

An investigation was started and 25,000 appointments for medical examinations were made. Twenty-two percent failed to appear; 19 percent had their claims denied, and 53 percent were allowed and 6 percent were deferred for benefits.

As specified in title I of the bill, it seems to me that the Administrator of the National Health Agency should be a physician. A member of the medical profession knows best the medical problems of the country as a whole and of various communities, and it is just as important that that Administrator be a physician as the Surgeon General of the Public Health Service.

Title VII—General medical services for families and individuals with low income: It is the privilege and the duty of every individual to take care of his own health. When because of financial reasons that is impossible it then may become the duty of the community, and then the State, and finally perhaps the Federal Government.

In those areas where people have low incomes grants-in-aid should be made for these individuals to help them pay their medical expenses. The plan of title VII proposes the appropriation of $200,000,000 to be used for this purpose, and a study made for 5 years to determine the needs, after which Congress shall review the program and determine the amounts to be authorized thereafter. It would seem more logical to meet the problem in this manner after a State-wide inventory of existing medical, surgical, and hospital care.

After a 5-year study, changes may have to be made in the program as proposed by S. 545, but at least this is a start in the logical American way of handling this problem. It would be very unfortunate should we borrow some of the schemes that have been in existence in Europe for many years and have not proven too successful.

As physicians, we are interested naturally in preserving the practice of medicine as it now exists and which has made the United States the medical center of the entire world, but we are interested even more so in preserving our American way of life. Much criticism has been heaped upon the American Medical Association and the physicians of this country during the past few years in which the critics have claimed the American Medical Association was a medical trust and physicians of the country are selfish individuals who are looking out for their own pocketbook. This is definitely not true. All of you know your own physicians, and, although there are instances in which overcharging has taken place, in practically all cases the physician gives his best service to his patient with a charge that is commensurate with the income of that individual.

It is interesting to note that in the Opinion Research Survey the question was asked, "Have you heard of the American Medical Association?" The answers were:

	Total, 1947	Upper income	Middle income	Lower income
	Percent	*Percent*	*Percent*	*Percent*
Have heard of AMA	74	92	83	61
Have not	26	8	17	39

The question was asked of those who knew of the association, "In general, do you approve or disapprove of the American Medical Association?" The answers were:

	Total, 1947	Upper income	Middle income	Lower income
	Percent	*Percent*	*Percent*	*Percent*
Approve of AMA	59	70	62	49
Disapprove	5	7	7	2
No opinion	36	23	31	49

If, after a survey, we do find gaps in medical care in the United States, they should be taken care of; but let us do it in our own way, the way that has made us such a great Nation.

STATEMENT OF MRS. DAVID N. HULFISH, ALEXANDRIA, VA.

Considering all the angles of the proposals for welfare legislation as specified in the Taft-Smith-Ball-Donnell bill, from financial appropriations to the proper and effective administration of the National Health Agency, advocated by this Senate bill 545, the general impression is that the advocates have reached the summit of a somewhat political honesty, much needed at the present time. Through the efforts of the sponsors to fill gaps in the present medical program, which will reach the lower income groups—the interest of all progressive politics—the Taft-Smith-Ball-Donnell bill has succeeded in making inclusions commensurate with our philosophy of life in America. The Senate bill 545 offers plans for voluntary health insurance, while the Murray-Wagner-Dingell bill proposes Federal compulsory insurance "paid for in the form of pay-roll taxes." The latter does not have the appeal for Americans that the National Health Act has, for the reason that the Murray-Wagner-Dingell bill bears the earmarks of the extreme left-wing technique, and these "too progressive" movements make it easier for a more radical movement to infiltrate into objectives.

MRS. DAVID N. HULFISH.

LETTER AND STATEMENT OF LEROY JONES, M. D., MANAGER, NEW MEXICO COOPERATIVE HEALTH ASSOCIATION, OLD ALBUQUERQUE, N. MEX.

JULY 7, 1947.

Mr. PHILIP R. RODGERS,
Clerk, Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

MY DEAR MR. RODGERS: Referring to your letter of the 23d of June and my reply dated June 30, I am sending herewith a copy of an address written and delivered by Sarah Bowen, M. D., at the annual meeting of the New Mexico Health Council, March 28, 1947. The purpose of my sending this is to present a clear picture of the situation in our State and to point out that our people are not able to bear their portion of the expense of programs for hospital building and for medical-service programs. Dr. Bowen is director of the Embudo Hospital at Embudo, N. Mex., and the description of the situation in her territory could be applied to all other isolated sections of the State, in none of which is medical service available, excepting the very few families who live close enough to a main road to enable them to transport them to physicians or hospitals at distances ranging from a few miles up to more than 100 miles.

Excepting the indigent, who are now cared for by the welfare organization, these people would like to be independent and to be able to pay their own way. However, their present economic situation as well as their past and, presumably, the future prospective situation will not offer them any relief. They simply do not have the money to pay prevailing medical and hospital fees and consequently do not have, as they never have had, the minimum, to say nothing of adequate medical service.

It is my belief that if they are ever to be afforded even moderately efficient and sufficient medical care, it must be brought to them and it must be subsidized in different degrees for different communities and for different families.

I desire to request permission to submit a more complete statement on these subjects, possibly in cooperation with the New Mexico Health Council or the Cooperative Health Association, or both, if and when the committee holds further hearings on these or similar bills.

Sincerely yours,

LeRoy Jones.

Plan of Participation of the New Mexico Cooperative Health Association, Effective July 1, 1947

The purpose of this agreement between the physicians and the New Mexico Cooperative Health Association is to provide medical, surgical, and allied services to the participating families on a basis which will be mutually benefical both to the physician and to the members of the association.

Therefore, it is understood and agreed as follows:

1. Any physician whose qualifications are recognized by the State medical society may participate in the program.
2. Services will be available only to family members of the New Mexico Cooperative Health Association falling within the income levels shown by the family fee schedule—medical program, copy of which is attached.
3. Each family participating in this medical service program will deposit with the treasurer the sum as determined by the family fee schedule—medical program. No family shall be entitled to benefits under this program until the full sum is received by the treasurer.
4. The treasurer shall be in charge of and liable for the funds. That position shall be duly bonded.
5. The duties of the treasurer shall be to deposit funds entrusted to him in a bank or banks selected by the association. The bank or banks in which the funds are deposited must carry Federal Deposit Insurance. The treasurer shall maintain a correct record of all funds paid in by the participating families and all moneys disbursed. The treasurer shall furnish such reports as are required by the physicians and the New Mexico Cooperative Health Association. The treasurer shall be paid for services rendered at a rate agreed upon between the reviewing committee of physicians and the association.
6. The association will furnish a list of the participating doctors, hospitals, and druggists, to each participating family.
7. It is mutually agreed neither the participating doctors, hospitals, druggists, nor the association shall be liable in any way for any cause or causes of action which may arise out of or in connection with the carrying out of this program. It is understoood that each participant's sole responsibility is to make a reasonable effort to perform the duties set forth in this agreement.
8. The participating families of the association are free to select any doctor, hospital, or druggist, from the list furnished. No effort shall be made to direct member families to any particular doctor, hospital, or druggist.
9. The attending doctor shall render such services as in his opinion are necessary under the terms of this agreement.
10. The doctor or hospital is under no obligation to furnish such services to a family; but if a doctor or hospital does furnish services to a member of a participating family, the said doctor or hospital shall look to the fund set up for payment of such service.
11. The treasurer will not pay for any services rendered by a doctor or hospital unless the name of such person is included on the membership card issued to the family. A record of the names of the members is maintained by the treasurer and the names of the family members are placed upon the membership card issued to each family.
12. The participating doctors and hospitals shall agree upon a schedule of fees to charge in rendering services to the participating families. At the end of each month each doctor and hospital will submit a bill for services or goods rendered. All doctor and hospital bills will be reviewed by the reviewing committee of physicians.
13. Six dollars of each fee deposited shall be set aside to pay for administrative costs. Administrative expenses of the treasurer, including his salary, bookkeeping supplies, bond, stationery and printing, post office box rent, money order charges, and fees paid members of the reviewing committee of physicians for attendance at monthly meetings to review bills shall be paid from the sum of the six dollars set aside. At any time the administrative expense exceeds the

remaining balance in the administrative fund, such deficit shall be paid as a preferred charge. The remaining part of the fee per family shall be available for disbursement as follows:

Each remainder shall be divided into 12 equal parts. One-twelfth shall be available for disbursement the month the family becomes eligible for service, and one-twelfth for each month following thereafter. Membership cards issued upon full payment of the participation fee to families entering the program for the first time shall be dated to be effective for one full year from the date of receipt by the treasurer of the payment. If the family holds a card currently effective at the time of the receipt of the payment for another year, the next card issued the family shall bear the expiration date of one year following the expiration date of the current card. If a family allows their membership in the group to lapse, then reenters the association, the family shall be considered a new member.

In every case the doctors and hospitals should inspect the expiration date of card. No service will be paid for by the association after a card has expired.

In the event of nonrenewal or of cancellation of the agreement for medical care service between the physician and the association, the one-twelfth of the families' participation fees representing months for which service would not be available, shall be returned to the families. At the end of each calendar month during the year covered by this agreement, all hospital bills made during that month, and approved for payment in the amount allowed by the reviewing committee of physicians, will be paid first from the one-twelfths available for disbursement that month. The remainder of the one-twelfths available for that month will be applied in payment of bills submitted by the doctors in the following manner:

(*a*) Each claimant will be paid the total amount allowed by the reviewing committee of physicians for services rendered during that month; provided, however, that the sum of such amounts approved for payment by the reviewing committee of physicians does not exceed the total sum of the one-twelfths available for payment for that month, less such sums approved for disbursement in payment of preferred bills.

(*b*) If the sum of the amounts approved for payment for doctors exceeds the total sum of the one-twelfths less the approved amounts of the preferred bills, said balance available to doctors shall be prorated to the doctors on the basis of the amount approved for payment to each doctor. The deficit borne by each doctor shall be recorded in a deficit account.

(*c*) If in any month the total amount of the one-twelfths available for disbursement shall excede the total amount of preferred bills allowed and paid plus the total amount of the doctor bills allowed and paid, said balance shall be recorded in a surplus account.

(*d*) At the end of the fiscal year the amount accumulated in the surplus account shall be applied on the amount accumulated in the deficit account as follows: The amount in the surplus account will be prorated among the claimants on the basis of the deficit borne by each and each claimant will receive his proportionate share. If the amount in the surplus account is not sufficient to pay the accumulated deficits, then the remaining portion unpaid to each claimant will be considered paid. If the amount in the surplus account is more than sufficient to pay the amount in the deficit account at the end of the year then said balance shall be carried forward for disbursement in the ensuing year's program.

14. Regulations regarding services: (*a*) Unless the member presents his card when asking for service, the association will not be liable for the bill.

(*b*) Waiting period for service: The family will not receive service for 15 days from the date of the card except in cases of accidents.

(1) The 15-day waiting period applies only to members whose cards are marked "New member." "Old members" will not come under the 15-day waiting period.

(2) Accidents as a result of drunken driving or reckless driving or injuries received while riding with a drunken or reckless driver will not be taken care of by the association.

(*c*) Medical service: The care the doctor usually renders in the home of the patient, in the doctor's office, or in the hospital, including prenatal, obstetrical, and postnatal care. The treatment of such diseases as mumps, whooping cough, influenza, typhoid fever, pneumonia, etc. Broken bones, burns, and accidental conditions requiring medical care, except as set forth in paragraph 14 (2) above.

(*d*) Surgery in cases of emergency: No elective surgery is permitted. No surgery for chronic conditions or conditions predating the card is permitted.

(*e*) Hospitalization in cases of emergency: Hospitalization in any case not to exceed such a period of time as deemed necessary by the attending physician and in no case longer than 15 days. In cases necessitating more than 15 days' hospitalization such costs in excess of 15 days to be borne by the family.

(1) Hospitalization in confinement cases limited to 5 days unless complications set in.

(2) Drugs and dressings used while in hospital will not be paid for by the association.

(*f*) Confinement cases: The association will not pay costs in confinement cases unless the family has been a participating member 10 months prior to delivery. Cards for new members will be marked "New member." Cards marked "Old member" will not be governed by the 10 months' regulation, since their membership and participation was continuous.

(*g*) Chronic cases requiring frequent treatment over a long period of time will not be treated by the association.

(*h*) Druggists participating in the program will give member families a discount of 20 percent on all drugs prescribed by participating physicians.

(*i*) Laboratory work: The association will pay for emergency laboratory work only.

15. In the event any question is raised by a participating family, a doctor, a hospital, or the association, it shall be referred to the reviewing committee of physicians for a decision. Its decision shall be final.

16. Should a participating family abuse its privilege to benefits provided under this program by making repeated, excessive demands upon his doctor or hospital, it is the duty of the doctor or hospital to report this abuse to the reviewing committee of physicians, which in turn will make known the abuse to the association. Should the family continue to abuse the service its right to the benefits under this program may be terminated by the reviewing committee of physicians after the family has been given a hearing. If services are terminated to any family, it relinquishes all claim to any money deposited with the treasurer.

17. It shall be the duty of the physicians to provide a committee to serve as the reviewing committee of physicians.

18. The physicians and the manager of the association will explain to all members of the association and prospective members that certain types of disease or illness are not accepted for treatment under the terms of this agreement and that payment for hospitalization or treatment for such cases are excluded under the terms of this agreement. The association and physicians will use diligent effort to secure health services for excluded cases through other agencies set up for servicing such diseases and illnesses.

The Voluntary Nonprofit Health Protection for Your Family

New Mexico Cooperative Health Association, Albuquerque, N. Mex.

The New Mexico Cooperative Health Association was incorporated under the laws of New Mexico on March 15, 1945. It was organized as a nonprofit association, its principal purpose being to secure medical care for its members on voluntary prepayment basis. The association has entered into service contracts with physicians, surgeons, hospitals, and druggists, who are members of, or are accredited by, the New Mexico Medical Society.

The association's activities are administered by a manager under the direction of the board of directors. The directors are elected by the members at annual membership meetings.

The fee for membership in the association is $1. Each member is entitled to one vote only at membership meetings. The medical-care services are available only to those members who have an average net cash income of less than $2,500, and who have paid the annual service fee.

The prepayment health program of the New Mexico Cooperative Health Association is designed to eliminate the financial hardships of catastrophic illnesses or accidents which befall individual member families by spreading the cost over the entire membership on an insurance basis. The program is designed to promote better health for the members, emphasize the preventive aspects of medical care, and encourage better distribution of medical personnel and facilities.

The nonprofit voluntary plan

Lifetime membership fee	$1
Medical care service:	
Annual fees:	
Single person	25
Husband and wife	40
Parent and one unmarried dependent child	40
Family of three or more	44
Member of participating family over 19	6

(Only unmarried dependent children under 19 years of age are eligible for service on a parent's card.)

The New Mexico Cooperative Health Association service fees are based on cost of operation plus a small margin which will create a reserve to take care of unforeseen emergencies. Any surpluses which accrue will be used to extend the services available to members.

Each member shall have free choice of any of the physicians, surgeons, hospitals, and druggists who are participating in the association's program; and each such physician, surgeon, hospital, and druggist shall have the privilege of choosing patients to be served in accordance with established custom.

MEDICAL-CARE—SERVICE TO WHICH YOU ARE ENTITLED

1. General practitioner care in the doctor's office, in the hospital, or in cases of emergency in the patient's home.
2. Prenatal, obstetrical, and postnatal care.
3. Treatment of diseases such as mumps, measles, whooping cough, influenza, typhoid fever, pneumonia, etc.
4. Broken bones, burns, and accidental conditions requiring medical care.
5. Minor surgery when emergency conditions exist, such as tonsilectomies.
6. Major surgery when emergency conditions exist, such as appendectomies.
7. Specialists' services when emergency conditions exist and service is prescribed by attending physician.
8. Hospital care (ward service) in emergency cases. Hospitalization in any one case of illness not to exceed such a period of time as deemed necessary by attending physician, but limited to 15 days. In cases requiring more than 15 days' hospitalization, such additional costs shall be borne by the patient: (*a*) Hospitalization in obstetrical cases limited to 5 days unless complications develop; (*b*) drugs and dressings used while in hospital must be paid for by patient; (*c*) if private room is used, patient must pay difference between private-room rate and ward-room rate.
9. Prescribed drugs will be furnished by participating druggists at a discount of 20 percent, cost to be paid by the patient.

EXCLUSIONS AND LIMITATIONS

1. Chronic cases—that is, cases requiring frequent treatment over a long period of time—will not be treated by the association. Tuberculosis, diabetes, rheumatism, arthritis, and anemia are examples of such diseases.
2. Accidents as a result of drunken or reckless driving, or injuries received while riding with a drunken or reckless driver, will not be taken care of by the association.
3. Confinement cases will not be taken care of by the association unless the family has been a participating member at least 10 months prior to delivery.
4. Emergency surgery will not be taken care of by the association unless the family has been a participating member at least 15 days, unless the surgery is necessary because of an accident.
5. Elective surgery will not be paid for by the association.
6. Eyeglasses are not provided under the association's program.

EDUCATIONAL PROGRAM

The association will sponsor and assist in holding community health education meetings by:

1. Cooperating with communities in planning and holding health educational meetings.
2. Furnishing trained leaders and speakers.
3. Showing moving pictures on health subjects.
4. Supplying printed educational material.
5. Cooperating with other agencies in holding health educational meetings.

The health problems of association members will be given prompt and preferred attention by association personnel. Arrangements will be made for use of services and facilities of other agencies, both public and private, in bringing both preventative and curative medical care to all members who need such services.

The New Mexico Cooperative Health Association is utilizing the services of an advisory committee made up of representative personnel from groups, associations and agencies concerned with the association's voluntary prepayment medical-care program. This advisory committee represents the following groups, organizations, and agencies:

1. New Mexico State Medical Society.
2. New Mexico Health Council.
3. Bernalillo County Druggists Association.
4. Farm Extension Service.
5. Southwestern Cooperative Societies.
6. New Mexico State Bar Association.
7. Labor organizations.
8. Participating hospitals: Southwestern Presbyterian Hospital, St. Joseph Hospital, W. and C. Hospital, Lindrith Hospital.

Board of directors: Herman Dinkle, president, Santa Fe County; Dr. L. R. Jones, Bernalillo County; Ben A. Kincheloe, Torrance County; George K. Shore, Valencia County; Manuel E. Sanchez, Socorro County; Manuel Padilla, Sandoval County; T. W. Stevenson, Rio Arriba County; Dick Gonzales, member at large; L. C. Timmons, member at large.

LETTER OF GEORGE F. LULL, M. D., SECRETARY AND GENERAL MANAGER, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

JULY 9, 1947.

HON. H. ALEXANDER SMITH,
United States Senate Building,
Washington, D. C.

DEAR SENATOR SMITH: It has come to my attention that a letter from Thurman Arnold, Esq., to Dr. Channing Frothingham, chairman, Committee for the Nation's Health, Inc., 1790 Broadway, New York 19, N. Y., dated July 2, 1947, has been introduced as part of the record of the hearings on S. 545 now being held before the subcommittee on Health of the Senate Committee on Labor and Public Welfare. That letter undertakes to call into question the good faith of the American Medical Association in its efforts to promote the health of the people of the United States. I respectfully request that this communication also be made a part of the record.

The American Medical Association, now 100 years old, was organized "to promote the science and art of medicine and the betterment of public health." It has endeavored to do so to the best of its ability by stimulating progress in medical education, by efforts to assure the purity and potency of medicinal preparations and the therapeutic value of apparatus, by exposing quack remedies and charlatans, by promoting rational medical research and by many other methods, including fostering the development of prepaid voluntary medical-care plans.

The intimation, implicit in Mr. Arnold's letter, that in those efforts the association, or any of its constituent or component units, have been motivated by a selfish or improper interest or that they have not had as an impelling objective the betterment of the health of the people, stems either from a lack of obtainable knowledge or from a disregard of knowledge actually possessed.

Mr. Arnold is quite correct that the council on medical service of the association has established "standards of acceptance for medical-care plans" and that it has granted its seal of approval to a number of such plans sponsored by medical societies that have met the standards so established. Plans developed by other groups must meet the standards established by the council if they are to receive its seal of approval, and a study of such other plans is now under way.

As to whether or not the enactment of S. 545 would tend to "increase the powers and the monopolistic control of organized medicine," which Mr. Arnold asserts it would do, the association has sufficient confidence in the integrity of the sponsors of the bill and in their sincere desire to promote the public well-being to be convinced that no such result is intended, nor will any such result ensue if the bill is enacted. Mr. Arnold is simply seeing implications in the bill not warranted by its provisions.

Sincerely yours,

George F. Lull.

Statement of J. T. Marr, Executive Secretary, Oregon State Federation of Labor

The subject of public-health legislation and Federal aid to the States in conducting health programs is one of major concern to the industrial workers of Oregon. In this State the percentage of the population under prepaid medical care is perhaps greater than in most States, yet it is unsatisfactory for a number of reasons, some of which are:

1. It is not available to thousands of persons because it is limited to groups.
2. It is limited in many cases to the person covered and is not available to members of the family of the person covered.
3. It often is restricted in ailments covered and in the amount of medical care or hospitalization.

During the war period some of the larger war industries provided prepaid health protection for which their employees paid a comparatively reasonable fee, but a fee which was not as low as would have been possible had not the influence of physicians through their organizations insisted on higher rates. Toward the end of the war some of these industries attempted to make the service available to all members of the family of an employee. Then, after the end of the war, one industrial hospital, located just across the State line outside of Oregon but serving the Portland, Oreg., area, was offered for use on a cooperative basis. But this has not met with a great degree of success, largely through the competition of older prepaid medical-care systems which have had, and still have, many restrictions in coverage as enumerated above.

Another condition that might seem to indicate Oregon is in a favorable position as regards public health is the comparatively large number of physicians in relation to population. But this, too, is diluted by the distribution of population, the sparsely settled portions of the State lacking in hospital facilities, and in the availability of a physician within a reasonable distance. In this respect, there have been numerous complaints of the lack of hospital facilities and at times of the lack of a physician in lumber camps, which often are isolated. Lumbering is the basic industry of Oregon, and the nature of the lumber camps has changed in the last two decades; they now are settlements of families, not just communities of male workers. Aside from the need of medical facilities to care for industrial accidents, there is a great need for these facilities for the health of wives and children of the men employed in the camps.

What may, by the use of statistics, seem like a favorable situation is in fact a condition that could be immeasurably improved if Federal funds were available for use in these special conditions. It is our opinion that a better attitude by the medical profession would be developed with a proper program of health conservation and treatment, not so much because of compensation of physicians partly from Federal funds, but more because physicians would become more alert if this slight step toward medical socialization were taken.

One large industrial concern (the Kaiser interests), which had considered a permanent industry here, proposed a health program and medical treatment through an unsubsidized organization. But this has not developed, and if it had, and were satisfactory for those participating, the problem would be solved for only those employed in the large industry, and in the aggregate these would be but a small part of the industrial population.

Recently the Oregon State Federation of Labor held its annual convention. The heads of the State Grange and the State Farmers Union addressed the meeting, and both stressed the fact of the need of persons engaged in farming to be included in the various social-security benefits. Health-program benefits, aided by government, surely would be of inestimable value to the farming population.

The present advantages in the Oregon situation—some of which are more illusory than real—instead of making our population complacent have the effect of disclosing to our people the great need for extension and improvement of health efforts.

It is our opinion that S. 1320 offers the basis for an adequate health-aid program, and we urge your committee to recommend its adoption. No other pending legislation, in our opinion, is adequate for a national program.

STATEMENT OF EMMETT J. MURPHY, WASHINGTON, D. C.

Mr. Chairman, my name is Emmett J. Murphy, of Washington, D. C. I am a chiropractor licensed in the District of Columbia, and director of public relations of the National Chiropractic Association. It is my purpose to express to you the general support of the National Chiropractic Association for the objectives of the two bills, S. 1320 and S. 545, presently before you for consideration, and to urge upon you the desirability of such amendments as are necessary to insure preservation of free choice of doctor by the patient in the event that either of these bills, or other bills having the same end, become law.

The National Chiropractic Association is formed on democratic principles, under which control of policy is vested in the house of delegates. There has been no meeting of the house of delegates since the introduction of these bills, and therefore there has been no opportunity for a declaration of policy.

The National Chiropractic Association promotes the public health, the standards of chiropractic education and research, and the art and science of chiropractic.

In the light of these professional aims of the National Chiropractic Association, a resolution was adopted in 1939 in support of legislation having the same objectives and similar in form and content to S. 1320. The resolution reads as follows:

"*Resolved*, That the executive board of directors of the National Chiropractic Association go on record as favoring the efforts of the President's committee to coordinate health and welfare activities, and recommend to our agencies and affiliated organizations that they give every cooperation to this committee in their efforts to bring about a better health service to our Nation.

"We further recommend that the committee always keep in mind the right of a citizen to choose his own doctor and method of healing and urge that the committee include doctors of chiropractic in the Federal health program."

Although the methods prescribed vary substantially between the two measures now before you, both bills appear to have as their primary purpose the removal or reduction of the economic barriers which prevent resort to timely and adequate health care on the part of the people generally.

Both bills would tend to promote a more widely diffused means of furnishing health care to individuals, regardless of the sparseness of population or lack of financial resources of individuals. There can be no controversy regarding the social desirability of such objectives.

In the Seventy-ninth Congress testimony was offered by the National Chiropractic Association in regard to S. 1606, and the principles then enunciated are reiterated in regard to S. 1320.

I wish particularly to offer again to the committee and to stress the need of the proposed amendments to S. 1606, Seventy-ninth Congress, which are equally applicable to S. 1320 and, if anything, are more urgently needed at the present time.

If the program to be authorized by S. 1320 is to succeed, it will require the services and the entire resources of all the healing arts. Chiropractic will inevitably play no inconsiderable part in the formulation and execution of the program. In every State and Territory, except four, chiropractors are licensed by law and serve the public health and interest in all those jurisdictions. Millions of people look to chiropractic practitioners for ministrations to their health needs.

The bill, S. 1320, is replete with such terms as "physician," "general medical and family practitioner," "medical practitioner," "qualified specialists and consultants," and "professional advisory committees."

It is of compelling importance to the patient and to the doctor that there be no possible misunderstanding, now or in the future, as to the precise meaning of these terms. They should expressly include chiropractic in consonance with State practice acts.

We must urge upon you the necessity of spelling out by affirmative language in the bill and in the committee report the intent of the Congress as to freedom of choice of practitioner beyond any possibility of future error or administrative caprice.

Whether in the language we suggest, or in other words of the same import, the National Chiropractic Association believes that positive safeguards must be provided to guard against monopoly and against the dead hand of vested interest in research, in administration, and in practice.

The principle that it is a function of the several States to prescribe the conditions of the practice of the healing arts is not only generally accepted but has been affirmatively stated by the Congress in major legislation of recent years. The Congress should meticulously refrain from infringing upon the regulatory domain of the States in establishing standards of preparation for practitioners of the healing arts and in defining the scope of practice.

Any broad national health program will necessarily operate within the practice regulations of the various States. The Federal program could not enlarge the legal license of a practitioner; whêther it can operate to devalue or destroy his license is another question.

Nor should a private organization be given the power of sanctions against an economic rival through lack of clarity in the law.

I reiterate our belief that it was and is the intent of the framers of this beneficent legislation that chiropractic is included in the scope of the health benefits provided for, and that legally qualified chiropractic physicians are eligible for furnishing those benefits; but there is nothing in this bill to insure against a contrary interpretation by the administrative authority.

The inclusion of our amendments can but strengthen that intent; their exclusion could in the future be interpreted by an administrator as license virtually to confiscate the practice of 20,000 chiropratic physicians.

Such an eventuality would be an unworthy deception of the people by leading them to believe that their contributions guarantee them complete health coverage when in fact they would be denied recourse to chiropractic wthin the benefits of this legislation.

It would further constitute a fraud on chiropractic patients contributing to the Federal plan, for they would be doubly taxed, first for the maintenance of conventional medical services, which in many cases they do not desire, and again for their own direct payment for chiropractic treatment which they do desire.

On the chiropractors themselves it would be an ironic double tax for which they would pay without even being included in the operation of the program which ultimately would be bound to destroy their profession unless protected by positive declaration of Congress.

Such a course is manifestly unfair and defeats the purpose of the legislation, since it execerbates rather than ameliorates the economic inequities this bill is designed to overcome.

It would also tend sharply to channel medical practice to narrowly constricted schools of medicine and of healing, to the exclusion of other established and reputable systems of the medical arts. This can easily and quickly degenerate into state medicine, as repugnant to the free institution of America as state religion.

Everything I have said, Mr. Chairman, in urging modification of S. 1320 to provide positive and clear safeguards against discriminatory administration applies with greater vigor to S. 545. The National Chiropractic Association must and does object to statutory enthronement of conventional medicine as a czar of a Federal health program. The statutory qualification of the administrator of the proposed National Health Agency as a medical doctor is utterly incompatible with the American philosophy of government.

Baldly, this is the corporative state.

It is foreign to the concepts of American free enterprise, contrary to public interest, and opposed to enlightened development of medical research and progress. Such a provision is retrogressive and inimical to democratic principles. It would virtually establish a state monopoly of health service leading swiftly and inevitably to overt discrimination and ultimate suppression of every dissenting school of therapy.

We are confident that the Congress will not knowingly encourage the further growth of monopolistic autocracy.

We are equally confident that, out of the long and careful consideration of the various proposals looking to the ultimate extension of health benefits to the entire population of the United States, highly desirable legislation ultimately will be enacted.

To that purpose we pledge our cooperation, asking only that a policy of nondiscrimination be spelled out in the act, to help preserve our American way of life.

Statement of National Organization for Public Health Nursing

May 19, 1947.

Because of their work in millions of homes each year, public-health nurses are in a specially strategic position to realize that a large proportion of the population has need of more adequate medical and nursing care. Through their national organization, they have officially endorsed a recommendation favoring the expansion of health-insurance plans with provision for nursing service, including nursing care in the home. They believe that in addition to voluntary effort governmental assistance is necessary for obtaining adequate distribution of health services.

Although realizing the limitations of S. 545, the National Organization for Public Health Nursing recommends that the legislation specify nursing among services to be provided in State plans, as well as professional nurse representation on planning and advisory committees. In making this recommendation, the National Organization for Public Health Nursing follows the principle that nursing service should be an integral part of any medical-care plan, because of the contribution nursing may make in preventing illnes or its recurrence, in shortening periods of illness, and in reducing the need for hospitalization through the provision of home-nursing service. Nursing representation on committees associated with the administration of such plans would be of value in planning for wise use of existing nursing facilities, in the establishment of measures required to insure quality of nursing care, and in the consideration of future nursing needs.

It is to be understood that the National Organization for Public Health Nursing in this communication refers only to title VII of S. 545. In connection with this title, the National Organization for Public Health Nursing recommends that S. 545 be amended so that, (1) a means test shall not be required as a prerequisite to benefit from community medical-care plans, (2) legislation should specify that nursing services be included, and (3) professional nurse representation should be provided for on planning and advisory committees.

REGARDING TITLE VII OF SENATE BILL 545, MAY 19, 1947

The National Organization for Public Health Nursing has taken no stand either for or against any specific national health bill. It has, however, since 1917 recognized the need for some type of prepayment plan by which comprehensive medical and allied care might be made more available to a large proportion of the population. Because of their work in millions of homes each year, public-health nurses are in a specially strategic position to realize the need for more adequate medical and nursing care. In 1944, and again in 1946, the National Organization for Public Health Nursing officially endorsed a recommendation favoring "the expansion of prepayment health insurance plans with provision for nursing service, including nursing care in the home. It believes that, in addition to voluntary effort, governmental assistance is necessary for obtaining adequate distribution of health services."[1 2]

Since its establishment in 1912, the National Organization for Public Health Nursing has been actively engaged in promoting community health programs through working with other professional and nonprofessional groups. Its specific contribution has been interpretation of the value of public-health nursing services in community programs, and the development of standards and techniques by which communities might be assured high quality of public-health nursing service. This service includes both health supervision and bedside nursing care in the home on a visit basis.

Membership in the National Organization for Public Health Nursing consists of approximately 9,000 public-health nurses, 1,000 nonnurse members, including representatives from other professions as well as interested civic leaders; and 350 member agencies throughout the United States. Agency membership is made up of both voluntary and official public-health nursing groups. Twenty-one State organizations for public-health nursing are associated with the national organization.

A joint committee of the American Nurses' Association and the National Organization for Public Health Nursing on Nursing in prepayment health plans has devoted considerable study to existing and proposed medical-care plans. Among these was S. 2143, introduced in the 1946 legislative session by Senator Taft. The committee noted with concern that no mention of nursing was made in this bill, although specific references were made to medical, hospital, and dental services. The board of directors of the National Organization for Public Health Nursing on January 23, 1947, endorsed the following recommendation of the committee:

Re health bill.—(*a*) If a bill similar to S. 2143 be introduced, steps be taken to secure specific mention that nursing care in the home be included among services in State plans; and (*b*) that should the bill make specific mention of professional groups to be represented in the administration by advisory or technical committees, nursing be so included.

In considering provision of S. 2143, the NOPHN Board was aware of the fact that the bill could not be considered a substitute for a health-insurance plan by which medical and allied care might be provided for a large proportion of the population. This bill and S. 545 make provision for only a limited segment of the population, those eligible for public assistance or those who might become so through application of a means test, with the resulting implication of charity. The NOPHN Board believes that any medical care plan which aims to provide for a large proportion of the population should not be based upon a means test.

The NOPHN views with concern other aspects of S. 545 but limits its discussion in this statement to the lack of provision for nursing in the bill. In recommending the inclusion of nursing in provisions of any bill such as S. 545, the Board follows two previously agreed upon principles that[1] nursing service is an integral part of health services and should be included in all prepayment health plans, and[2] that the nursing profession should be represented in both the planning and administrative phases of prepayment plans that include nursing service as a benefit.[3] (A copy of the Principles is attached.)

Studies of health insurance plans which have included nursing service have indicated that, in addition to routine nursing care in hospitals, the subscribers needed private-duty nursing in home and hospital for critical illness, nursing service in the home on a visit basis, and practical nurse service.[4] Because hospitalization may be provided by the States under S. 545, it is suggested that home nursing service in State plans should be encouraged by the addition of appropriate provisions in the bill. When home nursing service has been included in health insurance plans, it has enabled persons to have nursing care where hospital care was inaccessible either because of geographic location or because of overcrowded institutions; it has eliminated need for hospitalization in certain instances, and has provided necessary nursing care where hospitalization has been shortened because of increased demands for hospital beds. In addition to or concurrent with visits for the purpose of giving bedside nursing care, health supervisory visits by public health nurses could also assist in shortening the period of illness and in getting the worker back to work, in the prevention of more serious illness, the recurrence or exacerbation of chronic illness.

By definition all recipients of public assistance would be eligible for care under S. 545. According to a published report, there were over 3,000,000 persons in the United States receiving public assistance in November 1946.[5] Of this number, 25 percent were receiving relief through aid-to-dependent-children grants and 64 percent through old-age assistance. Some voluntary public-health-nursing agencies now have contracts with local welfare departments to provide nursing care for these groups. Voluntary public-health-nursing agencies, however, are finding that the chronically ill in the old-age group often require simple repetitive care which can be safely given by practical nurses working under professional supervision.

---

[1] NOPHN Resolves —, Public Health Nursing, vol. 36, No. 7 (July 1944), pp. 309–310, 351.

[2] NOPHN Resolves —, Public Health Nursing, vol. 38, No. 11 (November 1946), p. 577.

[3] Nursing in Prepayment Plans—Tentative Statement of Principles. Endorsed by NOPHN Board of Directors, September 1946. Endorsed by Board of Directors and House of Delegates of the ANA, September 1946.

[4] Herringshaw, Hazel. Nursing in Prepayment Medical Care Plans, American Journal of Nursing, vol. 46, No. 9 (September 1946), p. 596–600.

[5] Public Assistance, Social Security Bulletin, vol. 10, No. 1 (January 1947), p. 31.

A home-nursing service for persons eligible for care under a bill such as S. 545 might be provided by various types of nurses: by public-health nurses in voluntary agencies or in health departments where the official agency's program includes bedside nursing care; by graduate registered nurses on a visit basis; and by practical nurses working with a community nursing service under professional nursing supervision.

In order to provide coordination and to prevent duplication of public-health nursing services, it has been recommended that one community agency be responsible for the administration of the program.[6] S. 545 provides that on or before 1949 the sole agency for administering the State medical-care plan be the State health agency. In implementing the proposed nursing benefit in S. 545, a unified or coordinated nursing service on the local level could be provided under the direction of the nursing division of the State health agency, either through the auspices of local health departments or through contracts with voluntary public-health nursing agencies. Nursing advisory committees on both the national and State level would contribute to planning for wise use of existing nursing service, as well as to the consideration of future nursing needs and of measures required to insure quality of service.

It is to be understood that the NOPHN in this communication refers only to title VII of S. 545. In connection with this title, the NOPHN recommends that S. 545 be amended so that (1) a means test shall not be required as a prerequisite to benefit from community medical care plans, (2) legislation should specify that nursing services be included, and (3) professional nurse representation should be provided for on planning and advisory committees.

Joint Committee of the ANA and NOPHN on Nursing in Prepayment Health Plans

NURSING IN PREPAYMENT PLANS—TENTATIVE STATEMENT OF PRINCIPLES

1. Nursing is an integral part of a medical-care program and should be included in prepayment health-insurance plans. Because coordination of medical and allied services is the most effective method of providing health services on a prepayment basis and because nursing care should only be given in connection with medical care, it is not advisable to set up a separate prepayment plan for nursing.
2. The nursing profession should be represented in both the planning and administrative phases of prepayment plans that include nursing service as a benefit.
3. Needs of patients indicate, in addition to routine nursing care in hospitals, the inclusion of private-duty nursing in home and hospital, nursing in the home on a visit or hourly basis, and practical-nurse service.
4. Request for nursing service in a prepayment plan may be instituted by the patient, his family, the physician, or others, but nursing care should be given only with the physician's approval and under his direction.
5. Standards of nursing care should be maintained. Quality of nursing service should be insured by the employment of adequately prepared nurses, qualified nursing direction or supervision, and by maintenance of good personnel policies.
6. There should be cooperative evaluation of nurses' duties so that the nurse is not called upon to assume responsibilities for which she is not prepared or assigned nonnursing duties that should be delegated to others.
7. Both subscriber and service-agency contracts should contain definite statement of policy regarding types and amounts of nursing service to be provided under the prepayment plan.
8. There should be a continuous program of publicity or public education regarding provision of nursing service on a prepayment basis.
9. Controls over use of nursing service should be the joint responsibility of the nursing profession, the medical profession, and the administrators of prepayment plans.

---

[6] Desirable Organization of Public Health Nursing for Family Service. Public Health Nursing, vol. 38, No. 8 (August 1946), pp. 387–389.

10. Problems of duplication and omission of services occur when medical-care plans employ their own nurses in areas where there are existing public-health-nursing agencies. The use of existing public-health-nursing agencies to furnish home-nursing service on a visit basis is advisable.

11. Standing orders, approved by a medical advisory board, should be available for routine nursing care, with other treatments given only upon orders from the physician in charge of the case, when nursing is given on a visit basis.

12. There should be adequate case records and reports of nursing service rendered to provide for accounting; for professional review and control of the nursing service; to contribute to the welfare of the patient; and to serve as a protection for the nurse, should any question arise concerning treatment and care given.

13. There should be concurrent study of the nursing service to provide a basis for future planning.

14. Payment for nursing services should be based on established community rates in accordance with salary scales approved by State or local professional nursing organizations. Payment to visiting nursing organizations should be on the basis of the charge made by the agency to the community.

Statement of Russ Nixon, Washington Representative, United Electrical, Radio and Machine Workers of America (CIO)

The United Electrical, Radio and Machine Workers of America, CIO, represents 600,000 men and women in the electrical, radio and machine industry. This union has long been in favor of a comprehensive program of national compulsory health isurance. Last year we submitted a statement to the Senate Labor and Education Committee of the Seventy-ninth Congress on this subject. We wish to reaffirm strongly the position we expressed in that statement. We wish to place ourselves on record before the 80th Congress as supporting the national health insurance and public health bill of 1947, S. 1320, and as opposing the Taft-Ball-Smith-Donnell bill, S. 545.

Our position on this legislation is determined by the needs of our members. Our members face a serious economic problem today. The weekly earnings of the average manufacturing worker fall at least $25 short of what is needed for a health and decency budget for a family of four. Soaring prices and increasing rents are further straining inadequate budgets. What little savings were accumulated have been wiped out to meet current living costs. Our members are threatened by unemployment, which has risen to considerable proportions in certain sections of our industry. With no measures yet taken to stop rising prices or to prevent and meet unemployment, the outlook for the future is serious.

The only way our members can get along on present earnings in view of increasing prices and rents is to cut down on necessities. We know from surveys in our union that our members have cut down on their consumption of meat, milk and other essential foods. Health care is a substantial item in the family budget. This is one of the chief needs that suffers in times of retrenchment of a family. Families are forced to put off dental care; they are forced to postpone operations that are needed; they call a doctor only when illness has become serious, not when it could be prevented. Our members and their families are not able to afford the best medical care that modern science has developed.

To meet this problem in some measure our union has encouraged voluntary group insurance plans. At present there are 300,000 workers in 243 companies covered by some type of voluntary group insurance plan. There is no doubt that in the absence of a comprehensive program for health insurance, these plans have helped our members and their families. But they fall far short of meeting the needs. We reviewed last year in our testimony the shortcomings of such an approach to the health problems of the people. Therefore, we will not do more than mention the fact that our experience has proved that the restricted services, limited coverage of dependents, unfavorable selection of risks, the high administrative costs, and the high membership fees that eliminate the persons needing protection most, characteristic of these voluntary plans, make them wholly inadequate to meet the health needs of our members and of the American people as a whole.

Nor is this need for a comprehensive program of health insurance for all the people met by the Taft-Ball-Smith-Donnell bill, S. 545. First, it legislates the charity idea of medical care—care of the needy. Who is needy would be left to the States to determine, with no standards set. People would be subjected to the degrading means test to prove poverty in order to qualify. The bill ignores the fact that the problem of payment for medical care is not a problem for 10 percent of the American people. It is a problem for 90 percent of the American people. Our members would largely be excluded from assistance under this bill; yet it is they—self-supporting Americans who are not paupers—who cannot meet the high costs of illness, often sudden, prolonged and catastrophic. To say that these people can simply join voluntary health plans, if they wish to, ignores all the basic deficiencies of this approach.

Secondly, even for the persons of "low income," once they submit to the degradation of qualifying as public charity cases, and for the 90 percent of the people not covered at all, under S. 545, the medical services rendered would be limited to those furnished through voluntary plans. These are ordinarily limited to hospital care or surgical care. The care of the doctor and dentist for illness that has not yet driven you to the hospital is usually not offered. What our members need is the economic freedom to see a doctor whenever they need one.

Thirdly, S. 545 would strengthen and entrench medical society control of the whole field of organized medical care. There are no Federal standards and no provision for enforcement of any standards. There is no assurance of any care even for the needy, if a State does not wish to undertake it. Within each State the medical and hospital care advisory council would be influential. The bill does not specify that consumers groups or labor groups be represented on this council. But it does explicitly require that State medical associations and State hospital associations be represented. Under the bill public funds would be turned over to voluntary groups to handle the problem of medical care without any standards set, without any safeguards provided as to quality of service, administrative costs, or any of the other matters so vital to citizens as patients and citizens as taxpayers.

Our union strongly supports the National Health Insurance and Public Health bill of 1947 as a measure that would afford comprehensive medical care to all the people on a sound insurance basis. This bill would cover all the members of our union and their families. It would give complete medical care, not just partial benefits. It would, as we stated in our testimony last year, organize the expenditures now made in a haphazard way for inadequate care along rational lines. The insurance principle is a tried and true American method of spreading the risk of unpredictable expenses. It has worked in the field of unemployment. It has worked in the field of old-age and survivors' benefits. We feel its extension to the field of health is imperative to meet the needs of the people.

We are not experts in the field of medical administration. But we feel that S. 1320 sets up a good, democratic system of Federal-State-local relations which would guarantee medical care for almost everyone in this country. It assures the active participation in the management of the program of both the consumer and the professional groups. It would tie together prevention and treatment of sickness which makes for good economy and good health.

We therefore oppose S. 545 as an unsound, inadequate, and degrading approach to the problem of payment for health care and urge instead a sound social insurance approach to afford comprehensive medical care to all the people.

Statement of Mrs. Theodore Oxholm, Chairman, Spokesmen for Children, Inc., New York, N. Y.

We appreciate the opportunity given us by this committee to again present our beliefs.

In 1946, Spokesmen for Children gave full support to the Maternal and Child Welfare Act of 1945, S. 1318, and favored title I, part B (the maternal and child health and services to crippled-children section), of S. 1606. We opposed the National Health Act of 1946, S. 2143, because of its underlying philosophy that set aside 25 percent of the people of this Nation as worthy of scant charity only and subordinate to their fellowmen.

We believe a positive approach should be taken to comprehensive public-health services; that the purpose must be to provide excellent health for the population as well as curative and remedial services. Title III of S. 1320 provides for the establishment of this kind of service. We commend it to the attention of this committee. We believe that Federal guidance with regard to standards of services and personnel is necessary to insure high quality care for mothers and children throughout the country. We believe that grants-in-aid to the States for this purpose should be made in proportion to a State's need and not in proportion to its ability to finance the service necessary to meet the need.

We believe that the philosophy of S. 545 is in direct contradiction to the generally accepted trend in public-health work.

It is predicated on the theory that approximately 25 percent of the people of this country are indigent and must be helped, but the help given should be kept to a minimum so that the 75 percent will not be unduly burdened. We do not believe that 25 percent of the population should be castigated as indigent. If it is possible to think so, then it is high time the diligent 75 percent offered positive, preventive health services that would give the less fortunate a chance to be healthy, well-nourished, and adequately cared for.

It bypasses both the Children's Bureau and the United States Public Health Service and establishes a Federal agency for health with the only requirement for its chief that he be a doctor of medicine with 5 years experience, licensed to practice in one State. We believe that the administrator of such vital services as are being contemplated should be required to meet qualifications more rigid than those required for the Surgeon General of the United States Public Health Service.

The medical care provided will be curative and remedial, but no provision is made for preventive care and health education. It simply provides for the extension of the poor care poor people are now receiving and provides no plan for improvement.

All decisions on the type and amount of medical care to be given will be made by a board whose members are exclusively professional medical and health insurance people. The consumers of the services have no voice in stipulating the kind of care they are to receive. To put federally subsidized health services exclusively in the hands of professional medical and health insurance people is contrary to the principle of our Antitrust Act. There are 150,000,000 people in the United States and about 127,732 of them are physicians. We think such a small minority should not have complete jurisdiction over the services to be meted out to the remaining millions at Federal expense. We believe the consumers of this service should be well represented on any committees, boards, or councils that administer this service, as provided in S. 1320.

We believe Federal standards should be set and met for any health services provided for the people at Federal expense, as in S. 1320. It is our experience that where standards are not set services deteriorate quickly and corruption creeps in.

Periodic examinations for school children will be provided, but no follow-up is required. A poor school health examination is a waste of time and money. With no follow-up, it is a total loss. We believe maximum standards should be set for the physical examination of school children and that these examinations should be followed by prompt remedial and corrective services when treatment is indicated.

We oppose a means test as a requirement for medical care. In the United States of America we like to believe that people who can pay and people who cannot pay should be entitled to the same standard of life-saving, health-giving care. The basic philosophy that every citizen has human rights in relation to the provision of medical care, seems lost sight of in S. 545.

MARY H. OXHOLM.

LETTER AND STATEMENT OF MALCOLM L. RAYMOND, M. D., JOHNSTOWN, PA.

JULY 9, 1947.

GENTLEMEN: The enclosed reprint still express the writer's convictions.

In addition, we submit the following:

During early 1946, we were led to believe we would be permitted to appear before the Senate committee holding hearings on S. 1606. It was our intention to plead that the Senate committee approach organized medicine and suggest that the component county medical societies of the United States be requested to ask a vote of its members on the question: Would they prefer to begin grouping members of the profession in order to offer the public better services for the same or less costs, with the many advantages enumerated in our reprint, to submitting to the provisions of act 1606?

Naturally, we would be asked what prospect existed that the profession would consider any such alternative. Accordingly, we mailed the enclosed questionnaire to the president of each State medical society and the District of Columbia.

Results were as follows:

Definitely "yes" for our alternative—17.

Opposed to S. 1606 but unwilling to speak for the members on the alternative—2.

Opposed to S. 1606 but believed the care of the sick should be left in the hands of the profession—1.

Opposed to S. 1606 and believing the people should be permitted to safeguard themselves voluntarily—1.

Opposed to S. 1606 and stating our alternative had met with a favorable reaction—1.

Unable to speak because new president was taking office—1.

Definitely "no"—1.

Total replied 24, or half the States.

We believed we had sufficient evidence to show that the profession was for any sane alternative.

It seemed we were not alone in our conviction that something more than a plan to defray and spread costs was needed. American Magazine for January 1946 published the results of a poll of 60 experts on the question of Government sickness insurance versus the present system. In connection with these replies, 59 affirmed it as their conviction that the success of any plan of prepayment must include grouping of the profession.

It was also our purpose, had we been permitted to testify before the Senate committee holding hearings on S. 1606, to urge that with the profession coming halfway, so to speak, as we had reason to believe it would if asked to vote, the act 1606 be laid back and organized medicine be given a period of say 5 years in which to prove it could put its own house in order. With preventive clinics housed under the same roofs, staffed by Public Health personnel, this neglected but important phase of medicine would be given great impetus. We would have, so to speak, a double-barreled gun to give both curative and preventive care. No plan to cover only costs offers any set-up to meet this imperative need for better prevention.

Unfortunately, we were not permitted to testify, once it was apparent we favored a reasonable compromise.

Since that time, considerable evidence has come up that organized medicine is swinging toward more groups. A recent plan for prepayment in New York City, controlled by top men in medicine, makes it a prerequisite that all subscribing members must be cared for by groups of doctors and not by individual practitioners. Surely if this is considered essential in our largest urban center, it should be a necessity in our thousands of semirural communities.

We are convinced that only by providing good work shops in these areas, will younger physicians and eventually needed specialists ever be persuaded to spread out from urban centers to where they are direly needed.

Concerning S. 545, we have some doubt as to whether it is actually needed. Many States have their own plans, in successful operation for some years, covering medical care for the indigent. It was part of our experience to serve as chairman of the county committee in one Pennsylvania county from the passage of the law for a period of several years. However, if in the process of passing such an act as S. 545, although it does tend to centralize such care under Federal control, the profession can be brought forward to meet Government half-way, and a real step forward taken, then it may be worth while.

Had we been permitted to testify before the present subcommittee, it was our intention to urge the same procedure in seeking a vote of the component medical societies on grouping the members. It would be more effective to point out to them that only by so doing, would the doctors aline themselves in strong, small groups where they could stand, backs to the wall, to prove they could handle not only the distribution of care but its costs, through their rapidly developing voluntary prepayment plans. In union there is strength. Thus they would offer an active offense, rather than a static defense.

In the long view, suppose S. 545 becomes law, and in the course of human events, economic conditions one day become such that the members of our population eligible to its benefits steadily increase. Though started as a voluntary plan, the natural tendency would be toward a more or less compulsory plan, as more and more of our people became eligible. Thus it might defeat the very purpose it was drawn to avoid.

To diverge slightly, we have foreseen the changes now taking place in governments, many years ago. There is a definite trend in the common man's economic evolution from the ancient days when to be a freeman, rather than a slave, was an honor. There have been and will be various upheavals along the route such as, of recent date, fascism, nazism, communism, etc. Years ago, we predicted that after World War II the present brand of communism would tend to spread over Europe and Asia. But even this ism is only a temporary and extreme evidence of man's struggle upward. We firmly believe it will all shake down eventually as man becomes more intelligent and aware of what is for his best interests.

Based on the evidence of years with Government sickness insurance plans in forty-odd countries, more or less compulsory, we have no doubt that the average man will turn more and more, with the passage of time, to the conviction that medical care should be left in the hands of the profession, but with Government aid, particularly as regard preventive medicine. It is this phase, not the curative, that should concern government, Federal, State, county and municipal, but it should dovetail with the diagnostic and curative care by the profession.

It is evident to any thinking citizen that the latter phase of medicine is a public concern, that doctors owe a duty to the public as well as to themselves.

Therefore, in summary, we hold that the important thing needed is to make a sane compromise. Invite organized medicine to step forward and cooperate with Government in both curative and preventive medicine. Offer to help create good workshops (Hill-Burton bill) in which trained men can sell their goods. We believe that only in this way will real progress be made.

Respectfully submitted.

MALCOLM L. RAYMOND.

[Reprint from the Pennsylvania Medical Journal, May 1942]

GROUPING LOCAL PRACTITIONERS—ANOTHER CONSISTENT CHALLENGER[1]

ONE ALTERNATIVE TO GOVERNMENT HEALTH INSURANCE

Dr. S. Wier Witchell said: "The rate of advance in medicine can be judged by what the country doctor is."

We have heard much about the costs of medical care. We will hear more. The subject has been popularized due to political propaganda and due to the many panaceas for scarcity proposed during the last economic depression. Scapegoat hunting has been popular also. The cart has been put before the horse. The public should first be concerned with quality and distribution. There exists a belief that one should begin with the superstructure and expect the foundation, the physicians, somehow to get in under. We would consider first the foundation. The keystone must be the family doctor, as the individual soldier is the keyman in our army of defense. This, most authorities concede. Then we, too, should be heard.

In colonial times the few physicians and hospitals were in the larger settlements. The population increased and spread. Doctors and hospitals went along. Later the private clinics came. Two causes interfere with giving the best in services to all. The highly trained physician remains in the larger medical centers. Yet over one-half the population and the present trend are rural. The method of rendering service remains the same as in colonial days, each physician a lone individualist. Yet the complexities and costs of prevention and of diagnosis and treatment steadily increase. Herein lie the fundamental faults of our system. There is need of something more. Add it and we may find the solution to four unsolved problems:

1. Effective preventive medicine.
2. Local consultations, and with specialists, providing needed, continuous postgraduate instruction.
3. Emergency bed care.
4. A painless method of payment where needed.

In preventive medicine, we refer to that which applies directly, not to our splendid public-health measures. Though not entirely our fault, we practitioners have held too long to the monkish attitude of secluding ourselves in the monastery of private individual practice for cure only. Why must the average citizen continue to be so woefully ignorant of preventive measures? The compulsory-insurance plans in operation in some 40 countries fail to provide the best in curative care and also fail in preventive care. Professor Armstrong in The Health Insurance Doctor states that in England, France, and Denmark there exists a growing conviction in organized medicine that preventive care must become the concern of the individual practitioner. The grouped physicians of an average community could and would provide preventive medicine where we fail as individuals.

---

[1] Dr. Malcom L. Raymond, of Indiana County (now of Cambria County), author of this editorial, has devoted years of study not only to the prevention of illness and the amelioration of human suffering but to the protection of the health of the people against the threats of political centralization.

Why burden our busy hospitals with diagnostic problems which should be solved locally? The pooled knowledge, experience, and equipment of all the local men, grouped under one roof, would usually meet the need and stimulate the participants.

Why must ambulatory patients travel repeatedly to the city to consult specialists? We can collect the cases and bring out the specialists at intervals to collaborate with the family doctor. The postgraduate instruction thus provided would be invaluable.

Why must the home function as a hospital, unless because of inaccessibility and cost and because rural people dread hospitals? A few beds in a local center would care for emergencies and facilitate solving diagnoses. The centers would act as sifters for the hospitals, passing on the more serious cases.

Once grouped in such centers, the doctors, cooperating with interested laymen, would decide when a group plan of payment is needed based on local conditions, keeping machinery simple and the costs at a minimum.

True, efforts have been made to solve the question of costs by organized medicine, private agencies, and Government bureaus. All are insurance plans and all fail to cover the item of paying the physician for all services. We repeat—only local plans keep operating costs at a minimum with premiums within reach of small incomes.

Go back with us a few years and follow the trend of thought of our leaders. The President's Committee, which made a survey of the costs of medical care, 1932, reported:

"Community medical centers: The Committee's most fundamental, specific proposal is the development of suitable hospitals into comprehensive community medical centers, with branches and medical stations where needed, in which the medical profession and the public participate in the provision of, and payment for, all health and medical care, with the professional aspects of the service under control of the professional personnel."

The minority report recognized the advantage of group practice in communities where practically all the physicians can be joined in groups.

The 10-point program by the house of delegates of the AMA in 1934 held that any new type of plan must leave the larger share of authority in the hands of the profession. In October 1934, the American College of Surgeons stressed local experiments. In February 1935, again the house of delegates of the AMA emphasized the local solution as opposed to a national plan. The famous platform stressed the local solution. In November 1939, Dr. Nathan B. Van Etten, president-elect of the AMA, said: "A system of medical service should be developed from the periphery toward the center * * *. Let us think of the school district, the township, the county, the State, and the Federal Government in that order in developing an American system of medicine under control of the American people." Paul de Kruif in Health is Wealth holds that health centers must be built, that they are not only lacking in many cities but "are almost nonexistent in vast rural areas * * *. These hospitals or centers would be run by local physicians. Here would be medical consultants to cowork and advise with the family physicians to establish informally that practice of medicine by groups of specialists which, without doubt, is the medicine of the future."

Recently, the proposed Federal-built 50-bed hospitals caused hundreds of physicians to write urging clinic centers instead—a cross section of the opinions of rural physicians.

We are not one of those who believe the day of the individual is past. We do firmly believe the time is here when we shall see a pooling of knowledge and means in a community of effort, and not only in medical care. Dr. Alexis Carrel in Man the Unknown writes: "Individuality is doubtless real, but it is much less definite than we believe, and the independence of each individual from the others and from the cosmos is an illusion." Will we heed the trend of the times?

Local clinic centers would provide in preventive medicine: (*a*) Cooperation with state and Federal health programs; (*b*) logical locations for state clinics; (*c*) effective knowledge on preventive medicine endorsed by the local professional group; (*d*) periodic health examinations for all ages, prenatal to senile; (*e*) preventive inoculations. In curative medicine: (*a*) Office space for the local professions, and specialists on the consulting staff and permanent staff as the volume of work warrants; (*b*) emergency beds; (*c*) clearing houses for gathering and sorting cases for local hospitals; (*d*) selection of research problems.

Public advantages based on economics.—(*a*) A uniform fee schedule; (*b*) an increase in public confidence due to better professional cooperation; (*c*) magnets to draw out cases now in need of care; (*d*) a sharing of the burden of free work now on the hospitals; (*e*) local coordination of all war-time activities concerned with health and emergencies.

For the profession.—(*a*) Preservation of the doctor-patient relationship; (*b*) a systematic set-up under professional control, embracing any rural county, to mesh with the various plans now in operation, filling gaps, and making them more efficient; (*c*) easy, frequent consultations at reduced cost, thereby stimulating local participants; (*d*) postgraduate study by association with consulting specialists locally and more convenient absence from practice to associate with them at intervals in the city; (*e*) stable professional income regardless of the form of payment; (*f*) reduced individual overhead; (*g*) rural attraction for the trained men of the city.

How establish such clinic-centers? If our law-makers must do something besides finding us collectively guilty as a trade organization, how about providing some good workshops? Rather than trying to devise some broad expensive plan and attempting to fit it like a poultice to the whole country, they might better vote the funds as grants-in-aid, leaving it to the state, county, and community to share the costs. Each center would be fitted to local needs as determined by the local profession and laity consulting together.

The communities of any average county could finance the creation of such centers as they have the local fire company once they are "sold" on the necessity by the county medical society. Such a program can be visualized as setting the foundation stones, the family doctors, in place, over which the four corners of our new structure would rise automatically.

Under our developing defense program, the need grows more apparent. Every worker must produce. The older physicians left in civilian practice must do more work, faster. Our economy may go into a serious tailspin after the war. Then these centers would prove their value still more forcibly. The predictions of H. G. Wells have proven uncannily accurate. The Shape of Things to Come he foresees very lean times for our Nation in the nineteen-fifties. It is possible that we may be forced to return to the pioneer custom of making each community a self-contained unit of the state.

Thomas Mann in The Coming Victory of Democracy presents his brief to prove that democracy will win. God grant that he is right. But a democracy may become bankrupt. Then what?

When the medical history of our times is written, may it not be said of us, like certain nations in contemporary history, that, in our own defense against centralization of power, it was again a case of too little and too late.

SUMMARY

The majority of our people, in rural areas, are in need of better care, better distributed.

The local clinic-center provides a sane solution, compromising between out present archaic system and government health insurance.

The latter is threatened because the many experiments tried stress the matter of costs only. The politician feels that he can "go us" one better in financing any public service, even medicine.

With the apparent cheapening of human life by accidents and warfare, we must be more vitally concerned in conserving our human resources.

We submit that there exists a challenge to organized medicine to advocate and work for such clinic-centers.

Come what may for nations and forms of government, better medical care, through the family doctor, must and shall carry on.

M. L. R.

STATEMENT OF LEON H. RICHMAN, JOINT COMMITTEE ON SOCIAL SECURITY, CLEVELAND, OHIO

The Joint Committee on Social Security is a composite group consisting of individual members and organization representatives drawn from a cross-section of our population. Though our members are largely concentrated in the Greater Cleveland area, we have felt considerably strengthened by the addition this year of two members from rural areas of our State, a trustee of the Ohio Farm Bureau from Ashtabula, and the chairman of the board of health of a strictly rural county, Geauga.

Our purpose as stated in our bylaws is (1) to study the needs for extension and improvement of the social security program; (2) to stimulate public understanding of these needs; (3) to provide the means for joint action.

The organizations represented on our committee are as follows: The American Association of Social Workers; the Welfare Federation of Cleveland; the Cleveland Federation of Settlements; the Cleveland YWCA, public affairs committee; the urban League of Cleveland; the National Lawyers' Guild, Cleveland chapter; National Association for the Advancement of Colored People, Cleveland branch; National Council of Jewish Women, Cleveland section; Progressive Citizens Committee of Cleveland; Cleveland Teachers Union (A. F. of L.); Union Buyers' Club (A. F. of L.); International Ladies' Garment Workers Union (A. F. of L.); Waitresses' Union (A. F. of L.); Cleveland Industrial Union Council (CIO); Congress of Women's Auxiliaries (CIO); United Electrical, Radio, and Machine Workers (CIO); Central Area Community Council; American Medical Social Workers, Cleveland chapter; Amalgamated Clothing Workers of America (CIO); Carpenters' Local Union No. 105 (A. F. of L.); and individual members representing the following interests: Church; physicians; medical students, Western Reserve University; staff of the School of Applied Social Sciences, Western Reserve University; Children's Aid Society and the rural interests as indicated above.

The majority of these organizations combined last summer (1946) to sponsor and participate in a public hearing on the National Health Act of 1945 as a community project. An occasion was thereby afforded for allowing support for the bill to become articulate. It offered also important education on current legislation for those who assembled the facts and interpreted them, for those who as members of a hearing body patterned after the procedure of a Government committee listened to the statements, and for the general audience which attended the meeting.

The emphasis was on the testimony presented, which, with a few exceptions, where a prominent individual spoke on his or her own behalf, was the official statement of the organization represented. The opposition was given an opportunity to appear, and a doctor, a dentist, and an insurance agent did speak against the bill. But they were confronted with a formidable body of evidence upon which the conclusions of the 22 other speakers were based when they came forward to support the National Health Insurance Act of 1945, then under discussion in Washington before the Senate Committee on Education and Labor. The unanimity of opinion as a community-wide expression was as striking as the sense of urgency with which the statements were charged in their desire to attack problems and apply the remedies provided by S. 1606.

The committee has waited with keen anticipation for the emergence of the latest version of a national insurance bill, since they feel unshaken in their belief that as the months slip by the problems clamor more loudly for attention. Only on a national scale can they be tackled with a scope and a breadth of vision commensurate with the need and with the ingenuity which is surely not beyond the mental resourcefulness of our democratic people. We have studied the terms of S. 1320 and we approve heartily its general conception, though we question whether in transferring its administration to State officials appointed by the governor it does not hold an illusion of workability which it may not be possible to achieve. But we feel altogether opposed to S. 545 for a number of reasons. Extended help for the medically indigent is needed, but it is provided in S. 1320 in the form which insures its meeting national standards. That which S. 545 provides for the medically indigent inevitably imposes a separate charity program with the present system left intact for all the rest of the population. It is with this latter group—the vast majority of American wage earners—that we are concerned, as we must be if we are really to move forward to lift the level of the health of the Nation to any appreciable extent.

In any society a certain small proportion are born with, or acquire so weighty a burden of physical or mental handicaps that they prove to be totally unemployable unless treatment can be given. One of the striking defects of S. 545 is that it lacks the practicable means by which the medically indigent can raise themselves to the status of medically self-supporting. The unemployed who later secures a job, under S. 1320, would start immediately contributing from his wages to the national insurance fund, thereby meeting his own needs and bearing his share of the general fund for national medical improvements—for hospitals, health workers, medical education and research, etc. Under S. 545, he would return, upon securing a job, to the former difficulties of meeting the separate doctor and hospital bills as they occurred, having been deprived under S. 545 of the opportunity of bearing the cost of such care by small, regularized payments. Charity may be justified as a stop-gap emergency measure. Congressional leaders have been eloquent in their denunciations of illusory emergencies. The program we need and want is for average conditions in the middle of the twentieth century reaching forward into the future, flexible and capable of change, as changing conditions may demand. The program we want would affect the Nation by meeting the needs of the average wage earner on an insurance basis. It would assist the temporary or permanent indigent by payment from the States of those premiums which indigents could not meet themselves. All would thereby qualify for the same quality and quantity of nationally improved care.

Since S. 545 is entitled a "National Health Act of 1947" we are forced to examine it in that light. It offers treatment of indigents by a separate system of hospital, surgical, and medical services, according to the discretion of each State. We feel this entirely inadequate to meet the national problem and deplore the lack of national standards for conditions of service, hospitals, and specialists as distinguished from general practitioners. Where are the provisions for our constantly moving population? Why should we neglect the obvious economy which would be achieved by a uniform collection of national funds?

The periodic physical examination of school children would undoubtedly further reveal the need of adequate care, but the bill omits to take the next and obvious step, namely, to arrange for required treatment. Under prevention, the bill mentions only $10,000,000 for the control of cancer. Have Senators Taft, Smith, Ball, and Donnell really studied statistics on the incidence of this hydra-headed monster? And do they propose to attack it with a wooden sword? It is well for Congress to respond to the public clamor for action but, S. 545 is certainly not what was demanded. It poses as a substitute for the insurance plan which was developed by medical and social thinkers after 20 years of effort, and translated into legislative form as S. 1320. The people will not be misled into thinking of S. 545 as a "national health act." They will think of it rather as a poultice applied to a running sore.

This spring, 1947, our committee, anxious to inform itself on the medical-care needs of our rural neighbors in this State, Ohio, arranged a meeting in order to hear Dr. A. R. Mangus, professor of rural sociology, Ohio State University. He drew attention to the relative advantages in health facilities of our county, Cuyahoga, as contrasted with that of the rest of the State. The infant mortality rate of some of Cleveland's suburbs is less than 20 per 1,000 infants born alive. The rural rate is three or four times this figure. There would seem to be a direct connection here with the fact that most rural areas in our State have no adequate hospital or related facilities. Twenty-three counties have no facilities at all, and 27 with a combined population of 638,651 (1940 census) have no general hospital registered by the American Medical Association.

The selective-service figures show a disproportionately large number of farm men rejected especially for mental or personality disorders, many of which would have proved amenable to early treatment. The rural areas have too few trained health workers, doctors, and dentists, and this condition is growing steadily worse. Since the war those young doctors drained from rural areas are not found to be returning. The small counties have 20 percent fewer doctors than when the war started. Few places in rural Ohio have even half the number of dentists needed. The problem of inducing more doctors and dentists to these impoverished areas will not be solved immediately by the Hill-Burton Hospital Survey and Construction Act. because the poorer areas cannot raise two-thirds of the money necessary to match the Federal funds.

Dr. Mangus pointed out the need of achieving easier methods of paying for services of all kinds. Our committee would like to draw the careful attention of the Senate Health Subcommittee to the great disadvantage under which we labor in this State. By the terms of H. R. 51, the so-called enabling act for medical prepayment plans, passed in 1941, the whole responsibility of operation is placed on the county medical society. Ten doctors must be included and 50 percent of the total must combine to initiate a prepayment plan. Therefore any consumer-sponsored plan is blocked.

We do not underestimate the difficulties ahead, nor do we believe legislation can solve human problems, remove prejudice, dispose of ignorance and stupidity in health matters overnight, but we do believe S. 545 falls far short of the requirements for our people. S. 1320 on the other hand, is built on solid foundations and can develop a tensile strength to withstand the strains of usage. In wartime our young men went forward to "the impossible" knowing only that it would "take a little time." In peacetime we suggest that Congress in pursuing the goal for all of our people of treatment and prevention of disease, and promotion of health, should adopt the slogan of the Seabees—"Can do."

LEON H. RICHMAN.

STATEMENT OF ARTHUR SCHUTZER, STATE EXECUTIVE SECRETARY OF THE AMERICAN LABOR PARTY, NEW YORK, N. Y.

JULY 1, 1947.

The American Labor Party respectfully urges this subcommittee to report out favorably the National Health Insurance and Public Health Act, S. 1320.

This bill seeks to fulfill a basic goal set forth in President Roosevelt's economic bill of rights, namely, "the right to adequate medical care and the opportunity to achieve and enjoy good health." It also is a recognition of the declaration by President Truman in his message to Congress dated May 19, 1947 (H. Doc. No. 261): "The welfare and security of our Nation demand that the opportunity for good health be made available to all, regardless of residence, race, or economic status."

The introduction of the 1947 Wagner-Murray-Dingell bill marks the fifth attempt in 8 years to enact a program of national health insurance. In a bold effort to defeat this essential legislation, a small group which controls the American Medical Association has, through its national physicians committee, engaged in a national campaign of misrepresentations and distortion concerning the nature and purposes of the measure.

In the last 5 months of 1946 alone, this group spent $300,000 to block the bill. These monopoly minded individuals evidently regard the public's health as merely a field for private profit.

The American Labor Party respectfully suggests that this Senate committee investigate the methods, the finances, and the aims of the so-called national physicians committee. Such an investigation may indeed constitute a necessary congressional purgative and a prescription ordered by the people for this small and selfish group of reactionary physicians. The American Labor Party recommends such an investigation as excellent public medicine for these individuals.

The American Labor Party welcomes the improvements in the 1947 version of the Wagner-Murray-Dingell bill.

1. Sections 231–235 set up a system of local administration under State-wide programs, and establish basic national standards to which each State is required to adhere in administering the plan for its own residents.

2. The 1947 bill extends coverage to civilian Federal employees and their dependents.

3. Section 220 of the bill sets forth in clear and unmistakable language the fundamental professional rights of physicians, dentists, and hospitals under the bill.

Thus, section 220 (b) provides that: "Every physician, dentist, or nurse agreeing to render services as benefits under this title shall be free to practice his profession in the locality of his own choosing, consistent with the requirements of the laws of the States."

Section 220 (c) provides: "Every physician, dentist, nurse, hospital, or other person entering into an agreement under this part shall be free to the extent consistent with applicable State law and customary professional ethics to accept or reject as a patient any individual requesting his services."

Section 220 (d) provides: "No supervision or control over the details of administration or operation, or over the selection, tenure, or compensation of personnel, shall be exercised under the authority of this title over any hospital which has agreed to furnish personal health services as benefits."

These simple affirmations of professional rights put to rout the groundless bug-a-boos raised by the national physicians committee concerning socialized medicine.

4. Section 216 specifically permits agreements under the bill with voluntary health insurance and similar organizations. This section spells out in detail this important principle which was recognized but not as completely expressed in the 1945–46 version of the bill.

5. Section 256 makes adequate and particular provision for rural areas. By providing for a minimum guaranteed annual income for services furnished as benefits by physicians, dentists, and nurses who locate in or settle in rural areas, by defraying the reasonable expenses of transportation to the rural area for individuals establishing practice in such areas and by offering loans to such individuals for office equipment, this section helps meet the special need of sparsely settled areas. As is stated in House Document No. 261: "Few doctors can be expected to practice today in sparsely settled areas or where prospective patients are unable to pay for their services." This section squarely faces this problem.

6. Section 251 provides for administration by a National Health Insurance Board of five members in the Federal Security Agency, rather than by an individual Federal Administrator. The President is to appoint three of these Board members by and with the advice and consent of the Senate; the other two are specifically designated as the Surgeon General of the Public Health Service and the Commissioner for Social Security. Moreover, at least one of the appointed members is required to be a doctor of medicine licensed to practice medicine or surgery in one of the States. During his term of membership on the Board, no appointed member is permitted to engage in any other business, vocation, or employment. Thus, this section provides for effective administration by a national board under the direction and supervision of the Federal Security Administration.

While the American Labor Party respectfully urges prompt enactment of the National Health Insurance and Public Health Act (S. 1320), we are opposed to the measure which has been introduced by Senators Taft, Ball, Smith, and Donnell (S. 545) as a substitute.

The Taft bill provides "medical charity" rather than genuine health insurance. It opens the door to pauper's oaths, means tests, and income classifications as requirements for eligibility. By so doing, the Taft bill disregards the plain fact that the problem of adequate medical care is not restricted to so-called needy persons. At least 70 percent of the American people are today unable to pay for the medical care they need. To reduce the problem arbitrarily to a charity level is to ignore the scope of the demonstrated need and to encourage the monopoly-minded concept that medical care is nothing more than a commodity for sale only to those who can buy it. This mischief of this bill would be particularly evident in exposing to the taunts of "charity" those school children who might obtain treatment under its provisions.

In its administrative features, too, the Taft bill is clearly objectionable. It hands over vast powers of control to the selfish group which dominates organized medicine; it fails to require that representatives of the public be included in the proposed National Advisory Councils; and it omits necessary professional standards to which private voluntary organizations should be required to adhere as a condition to receiving public funds under the bill.

The American Labor Party respectfully urges:

1. Prompt enactment of the national health insurance and public health bill (S. 1320).
2. Rejection of the Taft "charity" bill (S. 545).

STATEMENT OF HARRY SEE, NATIONAL LEGISLATIVE REPRESENTATIVE OF THE BROTHERHOOD OF RAILROAD TRAINMEN, WASHINGTON, D. C.

JULY 10, 1947.

Mr. Chairman and members of the committee, my name is Harry See and I am national legislative representative of the Brotherhood of Railroad Trainmen, with offices at 130 Third Street SE., Washington, D. C. Our headquarters are located at Cleveland, Ohio.

The Brotherhood of Railroad Trainmen has carefully considered the two national health bills now before the Congress of the United States. As a result of that consideration and speaking in the names of our 190,000 members throughout the United States, we wish to record our determined opposition to S. 545, the Taft-Ball-Smith-Donnell bill, and our strong endorsement of S. 1320, the National Health Insurance and Public Health Act of 1947, introduced by Senators Wagner, Murray, Pepper, Chavez, Taylor, and McGrath. Our reasons for taking this position are set forth herewith. We respectfully ask that they be given full consideration by the committee in its deliberations.

When our brotherhood was organized 55 years ago, one of the first and most important items discussed was that of caring for our sick and disabled members. Ever since then, our members have experimented with various plans designed to assure quick access to needed medical care and to relieve our families of the fear caused by the unpredictable costs of illness. Our experience has been wide and the plans we have tried have been varied. We were once dependent on charity medical care. We have endured paternalistic plans under which we were given limited care as a favor and not as a right. We have experimented with systems in which management and labor cooperatively tried to solve the problem. And we have some excellently managed, but still not inclusive enough, programs run by our own representatives.

Our members have had experience with plans providing only emergency services and with those providing care for expensive illnesses as well. We have tried plans which provide cash indemnity in lieu of medical care. And, in the case of a very few of our major railroads, we have developed programs providing fairly complete and quite excellent care for the railroad employee if not for his family.

We mention our experience in detail because certain State medical societies testifying before your committee have talked only in terms of the prepayment plans under their control. They have implied that only their experiences were valid. They have urged that if Federal funds be used for medical care, they be turned over to plans set up by doctors; limited in service by doctors; their costs to the public fixed by doctors; and the fees to be paid determined by those same doctors who are to receive them.

We respectfully point out that whereas medical societies have actively concerned themselves with this problem only since 1939, our experience goes back over five decades. Whereas medical society plans are limited both in area and in coverage, ours have been of all types and reflect experiences in every part of the United States. As conductors, brakemen, yardmen, stewards, and operators of intercity busses, our 190,000 members in the United States live and work in every section of the country. The medical care problems of our families are those of families throughout the United States. Our experience should prove of value in analyzing proposals for a national health program.

BASIC PRINCIPLES OF A NATIONAL HEALTH PROGRAM

As a result of our experience, it is clear that any program designed to assure the people of these United States access to adequate medical care, should rest on certain basic principles. It is in the light of these principles that we have analyzed S. 545 and S. 1320. They are as follows:

(1) The plan should be inclusive. It should provide for all members of the family and not for just the wage earner. The illness of a wife can wreck a family budget just as thoroughly as can the illness of the father. A sick and unattended child is even more a cause of fear and worry than is an adult deprived of medical care.

(2) Participation in financing the program should be compulsory rather than voluntary. The need for a better way of paying for medical care affects not just a few but over 80 percent of our people. In the interests of the Nation, our people need as ready access to medical care as to schools, police protection, or paved roads. What the people as a whole need should be paid for by the people as a whole. And in the field of medical care it has become peculiarly true that only by a total pooling of funds spent for medical care in each community, can each community be assured of adequate hospitals and of enough doctors and nurses and other necessary personnel.

(3) The plan should be comprehensive in its services rather than limited; should provide complete care rather than just surgery and hospitalization. It is far better to keep people well than to attempt to patch them up after illness has become serious. It is better and less costly for people to see their doctors when illness is just beginning instead of when it has grown to major proportions. Prevention is better than cure.

(4) Medical care should be available as a right for which people have paid rather than as charity. Our people insist on paying for their care, each in proportion to his income. Our people have a right to medical care, each in proportion to his need. We insist on a pooling of funds on the American principle of insurance. Americans will refuse to accept charity medical care paid out of tax funds and granted only after snooping investigations into their family lives.

(5) The program must leave the people free from bureaucratic control. Free

to choose and to change their doctors. Free to see their doctors without political or other clearances. It must leave the doctor free to take or decline patients, must encourage him to advance in his field, must reward him properly.

(6) The program must be controlled by the people through representatives of their interests. It must not be controlled by organized medicine. A national health program does not primarily involve questions of medicine. It involves questions of collecting and distributing the people's money; questions of how the people can pay for their medical care. It should be run by and for the people.

CONCLUSIONS REGARDING S. 545 AND S. 1320

In the light of these principles, the Brotherhood of Railroad Trainmen insists that S. 545 does not represent a national health program and will not contribute to a solution of the problem. In fact S. 545, if passed, may well prevent us from solving the problem.

S. 545 could not possibly aid more than 5 percent of our people—the problem affects us all. S. 545 provides charity medical care and only to those willing to beg for it—we refuse to accept charity. S. 545 could force us into a single plan and deprive us of freedom of choice. S. 545 provides so little money that either doctors would have to accept a pittance for their services or the quality of medical care given would be lowered disastrously. S. 545 would vest monopoly control of the peoples' health and of the money people spend for health in the hands of the politicians of organized medicine. For these reasons we vigorously oppose the passage of S. 545.

On the other hand, we find that S. 1320 really is a national health program. It would meet the needs of 90 percent of our people. It is based on insurance rather than on charity. It gives medical care as a right rather than as relief. It guarantees freedom of choice and local control of administration. S. 1320 assures high quality of care through the setting of Federal standards. It assures professional freedom, adequate incomes, and incentives for advancement to doctors. It requires neither mean tests nor hordes of investigators. And it keeps control over public funds in the hands of the public.

Our only reservation as regards S. 1320 is that it does not provide for the automatic inclusion of railroad workers and their families. We understand this to be because of the extensive development of our own programs. We are aware also that section 205 (a) of the bill makes possible the payment of our premiums into the insurance fund by the Railroad Retirement Board. We would point out, however, that even the best of our programs does not as yet provide complete care for our families. Should this not develop and should it prove impossible to cover our membership through section 205 (a), we will request the sponsors of S. 1320 to so amend their bill as to provide automatic coverage for our membership.

Despite this one minor reservation and for the reasons set forth above, the Brotherhood of Railroad Trainmen heartily endorses S. 1320 and, in the interests of the Nation, requests the Congress to promptly pass the National Health Insurance and Public Health Act of 1947.

STATEMENT OF J. S. SMITH, PRESIDENT, VIRGINIA STATE FEDERATION OF LABOR

JULY 3, 1947.

The membership of the Virginia State Federation of Labor naturally is vitally interested in national health insurance. However, we feel that we must approach the situation, from a selfish point of view, more or less, and to consider a national health insurance program from the standpoint of how such a program will affect the people of our Commonwealth.

It is our opinion, for the reasons hereinafter stated, that we must look with favor upon the provisions outlined in S. 1320.

For example we find the following conditions to exist in our Commonwealth.

I

(*a*) *Economic resources, 1940.*—Average per capita income, $450; average per capita savings, $101.

These figures definitely convey the inability of the average citizen of Virginia to provide for himself and his family adequate health services. We feel that S. 1320 accords an opportunity to the person of low income to participate in a program that does not impose financial hardship, nor does it suggest the stigma of charity.

(*b*) *Need for national health service.*—Health status of the population: Annual death rate per 1,000 population, 1940, 11.1; infant deaths per 1,000 live births, 1940, 58.5; annual deaths per 100,000 by heart disease, 1940, 249.3; annual deaths per 100,000 by tuberculosis, 1942, 49.5.

Selective Service data: Rejection rate per 1,000 registrants, February to August 1943, 52.2; percent of registrants accepted with defects, 15.9; percentage distribution of principle causes of rejection from April 1942 to March 1943:

	Percent		*Percent*
Mental disease	11. 0	Musculoskeletal	7. 4
Syphilis	10. 7	Hernia	5. 2
Cardiovascular	8. 6	Eyes	6. 7

The foregoing figures and percentages definitely establish the need for a national health service program in Virginia. It is reasonable to assume that a contributing factor is the lack of proper health facilities in rural areas. Based on the inability of the inhabitants of rural areas to support necessary health services and facilities as set forth in section (a). With the passage of S. 1320 this condition would be alleviated, as set forth in section 256, entitled "Rural Areas."

(*c*) *Inadequacies of health personnel and facilities in Virginia.*—Health personnel: 1 physician for every 1,171 persons, 1940; 1 dentist for every 3,173 persons, 1940; percent of population covered by full-time health officers, 1940, 72; per capita local health department expenditures, 51 cents.

General and special health facilities: Population per hospital community, 1944, 60,400; hospitals per community, 1944, 1.60; beds for community, 1944, 151; beds per 1,000 population, 1941, 2.6; percent of beds occupied, 1941, 68.1; average days of care per person, 0.64.

Section 202 (b) and (c); section 235 (a) (1) through (6) and section 242 (a) (5) (A), (B), and (C) of S. 1320 provide methods for correcting and improving conditions such as those mentioned above. Again we find that much of the above is attributed to the fact that the State of Virginia is approximately 65 percent rural and suffers the inadequacies of health personnel and facilities common to rural States.

(*d*) *Voluntary prepayment plans.*—We find in Virginia, as is true in many other States, that a very small percentage of the population is enrolled in voluntary plans. The reasons for this are many: (1) It is common practice for persons who for several years have not suffered illnesses to any degree and consequently have not directly needed medical attention to assume the attitude that because of the lack of need for these services there will be no future immediate need; (2) many who have participated in voluntary plans for from 1 to 2 years without having to avail themselves of the benefits other than protection are prone to assume the attitude that, "for 2 years I have paid money into something from which I have received no direct benefit. Why then, should I continue to pay? I'll take a chance that maybe I won't need the services offered and will place that money to some other use"; (3) many persons are of the opinion that voluntary prepayment plans are large profit-making schemes for insurance corporations.

The small percentage participating in such plans in Virginia is evidenced by the estimate that of a population of 3,000,000 people only 293,054 are enrolled in prepayment plans, or an approximate 10 percent. S. 1320 will make available to approximately 95 percent of the population, among other services, such services as are not presently available under voluntary prepayment plans.

II

S. 1320 provides the only practical method for administering a National Health Service program. Those persons responsible for the administration of such a program certainly should be chosen from among the persons most familiar with the national, State, and local needs. We compare this in some respects with the OPA program during the war and notwithstanding the fact that many persons were, for presumably selfish reasons, critical of the administration of that program, its accomplishments toward advancement of the war effort will long be remembered.

S. 1320 also will continue the present spirit of competition among the services and facilities by allowing the individual participant to choose from all those services and facilities participating. It also continues our democratic princples by providing for voluntary participation in the plan by these services and facilities and provides for the setting of fees comparable to regional, State, or local conditions and practices if so elected, or by other means if desired.

We are particularly in accord with the provisions of section 242 (d) providing for administration of the plan by the National Board in cases where the State fails to act or does not carry out its plan as set forth. Since we are citizens of a State whose governing officials have announced themselves in opposition to Federal aid in specific instances, we can appreciate the need for such provisions.

While we are in accord with the general provisions of section 251, we take the liberty to recommend that subsection (a) be amended to provide for an increase in the salary rate for Board members from $12,000 to $15,000. We make this recommendation because it is our belief that this is the lowest figure at which competent personnel may be secured.

The Virginia State Federation of Labor has for many years looked with anxiety, to such a program as S. 1320 provides. We believe this to be a step in the proper direction, the results of which will be a stronger and much healthier Nation.

We are aware that separate financial legislation is necessary to provide means of raising sufficient revenue for the administration of a program such as outlined in S. 1320. We therefore wish to record ourselves as in accord with a method of pay-roll deduction sufficient to meet the amounts appropriated under this bill.

III

We must look with disfavor upon the provisions of S. 545 for the following reasons:

(1) This bill attempts to meet the Nation's existing health-service needs purely on a charity basis. Few people would resort to this method of medical care except in extreme emergencies.

(2) Coverage under S. 545 would not extend to more than 4 percent of the actual population. This is brought about by the provision allowing moneys already being expended by State agencies to be counted as part of the State's matching contribution.

(3) S. 545 does not define who an indigent person might be. Persons with incomes ranging from $2,000 to $10,000 might be unable to finance a serious or prolonged illness.

(4) It does not provide the incentive for States to participate in compulsory or reasonable health-insurance plans since no Federal funds are available under this title.

(5) S. 545 does not provide for a comprehensive health-service program but relies on enrollment of needy individuals in voluntary prepayment plans which are inadequate in furnishing necessary insurance.

(6) Lack of Federal control over this program: The Federal Government is without authority to set minimum standards for proper medical care.

(7) S. 545 does not provide for practical administration inasmuch as administration of the program is vested solely with the representatives of the medical profession.

(8) S. 545 makes no provision for the expansion of already inadequate health services and facilities.

(9) S. 545 offers no permanent solution to our health-service problems in Virginia.

We desire to express our appreciation to the chairman and the members of the committee for according us the opportunity to present our views regarding this matter, which we consider to be of major national importance. We sincerely trust that the opinions contained herein will be of some value to the committee, and in a manner that will influence the committee's recommendation to the Congress.

Respectfully submitted.

J. S. Smith.

LETTER OF FAYE STEPHENSON, PRESIDENT, CONGRESS OF WOMEN'S AUXILIARIES OF THE CIO, CLEVELAND, OHIO

JUNE 17, 1947.

SUBCOMMITTEE ON HEALTH OF THE
SENATE SOMMITTEE ON LABOR AND PUBLIC WELFARE,
Senate Office Building, Washington, D. C.

On behalf of the Congress of Women's Auxiliaries of the CIO, I want to urge your committee most earnestly to support the national health-insurance bill, S. 1320.

Our members, who are the wives and mothers of workers' families, know from their personal experience that there is widespread and grave need throughout the Nation for the medical services which this bill would make available as a right to employed and self-employed persons and their families.

As housewives, who have to manage on very limited incomes, we have seen members of our families go through illness without any or without adequate medical attention. We have had the bitter experience of seeing our children and our husbands develop physical defects and lifelong handicaps simply because we were not able to get or could not afford the medical advice and care which they needed. We know that in numberless cases our women have become chronic cases of physical disorders because they were unable to get the proper advice and care before, during, and after childbirth. We know of thousands of cases where one serious illness has used up modest lifelong savings, forced the mortgaging of homes, or resulted in debts that would take years to pay off.

As your committee doubtless knows, most workers' families are in the income group which cannot afford adequate medical care at present. Under the pressure of meeting daily living expenses millions find the voluntary health group plans too costly even when employed, and of course find them completely out of their reach when unemployed.

We know, from experience, that most of our workers' families will not accept medical services on a charity basis. They would rather do without essential medical care than submit to a needs test or charity standard. This is a basic standard of personal dignity which these families will not easily sacrifice. It is a standard which we feel our legislators should do all in their power to encourage and preserve.

Because of this we are convinced that the charity health program sponsored by Senator Taft and his associates in S. 545 will not meet the needs of the vast majority of American families who at present cannot afford proper medical care. These families simply will not submit to the charity stigma. This bill would, therefore, be of no value to a very large proportion of our population who need health protection.

We are convinced, on the other hand, that these millions would take full advantage of the medical services to which they would have a right under the insurance principles established in S. 1320.

In closing I want to again urge your committee to endorse this bill, which would establish a truly national health program of benefit to all the people.

Very truly yours,

FAYE STEPHENSON.

JULY 10, 1947.

STATEMENT OF DR. ARTHUR J. TODD, MANAGER, CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION, WASHINGTON, D. C.

Gentlemen of the Senate Committee on Labor and Public Welfare, somewhat over a year ago it was my privilege to present to the then Committee on Education and Labor a statement from the Christian Science churches on the subject of compulsory health-insurance legislation. That statement was directed in opposition to S. 1606, the so-called Wagner-Murray-Dingell bill. It represented the view of the groups totaling millions of citizens who do not rely upon medicine or medical treatment for health and healing, and who would be penalized by the provisions of such legislation.

You now have before you S. 1320 sponsored by essentially the same group of legislators whose measure we opposed last year. It is true that the present bill bears evidence of considerable revision in matters of detail; but fundamentally it remains identical in principle with its earlier versions, notably S. 1606. Even though ostensibly assuring beneficiaries free choice of physicians, creating an advisory council, and setting up a partnership between States and Federal Government, the utterly centralized control of the Nation's health according to a preconceived and exclusive path by which it is to be attained, still remains not only implicit but explicit in the bill. Control is placed in the hands of a National Health Insurance Board, located in the Federal Security Agency, whose functions shall be administered by the Board, "under the direction and supervision of the Federal Security Administration."

Consider how this highly centralized control will attain its ultimate degree if legislation now before the Congress should be enacted, whereby the Federal Security Agency should become a Department of Government and its head a Cabinet officer.

Moreover while S. 1320 skillfully avoids any specific and detailed reference as to how the health-insurance and public-health program is to be financed, it is understood to depend, like its predecessors, upon universal compulsory contributions or deductions from wages to provide for its "prepaid personal health-service benefits," which constitute the substance of title II of the present bill.

For these reasons it seems wise to include in this present statement the gist of what was presented last year in opposition to S. 1606. We are emboldened to do so particularly because a leading medical journal announced that "one of the most cogent arguments in opposition came from Christian Scientists. The spokesman for that church introduced more clearly than anyone else the essential philosophy involved in this debate."

We as Christian Scientists are unalterably opposed to any legislation which would interfere with our right and that of others to enjoy and to practice freedom of religion. We are convinced that S. 1320 would do just that. So in the name of millions of Americans, not alone Christian Scientists but many others who have sought and found satisfactory means to health other than those contemplated in this bill, we object to the establishment by law of a monopoly for one branch of the healing arts. Monopoly and coercion are foreign and repugnant to the sentiments and traditions of free America.

The authors of this legislation base their argument for it on the ground that only through the use of compulsory insurance will many people be able to pay the expenses of sickness. All are to be taxed for this purpose. But what of the many who cannot, because of their convictions, accept the remedies provided? They have been taxed. The Government has taken its deduction for medical care out of their weekly pay. They do not wish the kind of treatment provided under the bill; but, as has repeatedly been brought out in testimony before this committee, they must either accept that in which they have no confidence, or pay themselves for the healing remedy of their choice.

If it is so difficult for many persons to pay once for medical care as the proponents of this bill declare in urging it, what shall be said of the difficulty of paying twice—once in taxes, and a second time in order to have the kind of treatment one desires?

Before going further, let me say that if this bill would actually produce all the good results claimed for it, we, as Christian Scientists, would not oppose it; we might ask for an amendment, but not defeat of the measure. By no means do we look at this legislation from our own viewpoint. We have in view the welfare of the general public as well. If the bill would greatly improve the health of the great majority who rely on medical treatment, we should certainly not object to its passage. But we are convinced that such beneficial effects would not follow. This judgment is based on increasingly convincing reports of the experience with compulsory health insurance in foreign countries, on testimony given by medical men at many congressional hearings, and on our own understanding of the nature of disease.

We believe that Government medical care, combined with cash payment during illness, would have the same tendency here as elsewhere to prolong sickness, to produce an inferior quality of medical care, and to lead many people to seek medical service when they did not really need it simply because they could get it without further expense. In short, we believe that compulsory health insurance would tend to minimize the will to get well and would foster unnecessary medication. This bill has a monopolistic angle that is not in keeping with American tradition of antitrust and equal freedom for all. Why should one form or branch of the healing art be set up exclusively as the remedy which people must accept and for which they must pay taxes?

It has been argued that to require citizens to pay taxes for medical services that will be of no use to them is no different than requiring all property owners to pay taxes for support of the public schools when some religious denominations prefer to maintain denominational schools of their own. On close examination this supposed analogy breaks down. In the case of compulsory health insurance Christian Scientists cannot take advantage of the supposed health provisions at all, because it is a violation of the tenets and teachings of Christian Science for Christian Scientists to accept and rely upon medical treatment. They have to have their own form of treatment, or none at all, if they are to stick to their religion. In the case of denominational schools, it is not a violation of the tenets and teachings of their religions for parents of these denominations to send their children to public schools; and they do so—in great numbers. Christian Science is a system of healing as well as a religion. Healing the sick through Christianly scientific prayer is an essential religious element. Christian Scientists believe that reliance upon material methods of healing is incompatible with reliance upon divine aid; and that it is not correct under divine law to rely upon both.

Christian Scientists know that the right of religious freedom is a constitutional right—a right which the majority of people wish to see preserved. They also know that, although their method of treating the sick runs contrary to the prevailing systems of today, it is an integral and inseparable part of their religion and therefore a constitutional right. They note with alarm that proposed plans for health insurance threaten to trample upon this priceless right, by establishing such so-called insurance on a strictly medical basis under the supervision, regulation, and administration of medical men and according to medical standards.

In these hearings it seems to have been assumed that health is merely an economic or physical issue. Many million beneficiaries of spiritual healing would, with eminently good reason, question that assumption. They would insist that this committee and the proponents of compulsory health insurance on a national scale face and answer the following question: Is there any more warrant for establishing a state medicine designed to embrace everybody than for establishing a state religion? State medicine is imperialism not democracy. It savors of the one-party system of our recent enemies which we have poured out blood and treasure to destroy. If, as we insist, healing is an integral part of religious faith and practice, any attempt to fasten upon this country a compulsory tax-supported system of health insurance is an interference with that freedom of religion guaranteed by the Bill of Rights. It in no wise clears away this obvious illegality to assert, as has been asserted in these hearings, that nobody will be compelled to accept medical, surgical, hospital, or nursing services contemplated under S. 1606. The requirement to pay taxes violates constitutional protection of religious freedom no less than would universal requirement to submit to compulsory medicine or hospitalization or emperor worship. To deny us the right to make freely our own decisions in matters of faith and health is indeed a very thinly disguised form of atheism. Would you dare to force us to accept and pay for a system of health insurance in the face of testimony before a similar committee last year by the highest health authority in our Government that confronted, for example, by the common cold, his profession has no preventive remedy?

Lest someone should gain the impression that if those who depend upon spiritual means for healing might become a menace to the health of the rest of the people, it should suffice to appeal to the record. Any insurance or health authority will tell you that we are law-abiding people and "good risks." We constitute no danger to public health, but on the contrary are a distinct asset to it.

We come before this committee not as opposing any system of medicine or surgery or health regimen. We do not desire to impose our way of thought or healing upon anybody. We believe in voluntary acceptance or rejection of political, religious, or medical beliefs. There is room in this broad land of ours for a great variety of patterns of effort and belief, and experimentation. There is plenty of work for all of us to do. We simply ask that we be permitted to enjoy the same freedom which as American citizens, supporting the American way of life, we are trying to sustain for others. For that reason our plea is not merely for the hundreds of thousands depending upon spiritual means for healing, but on behalf of all the American people whose fundamental freedoms are threatened by this projected legislation.

Therefore, with all the strength we can summon we must and shall continue to oppose this specious offer of insurance to the American people as a none too subtle invasion of their basic constitutional rights and threatening to impose an undeclared but inevitably huge financial burden upon them. We oppose a very obvious and burdensome evil masquerading as a contingent good. Christian Scientists urge you to beware of this latest form of a benevolent despotism which we had hoped our forefathers swept away a century and a half ago. We urge you not to attempt to force healing effort into a single mold, but to rally all the health potentialities of our country, to encourage them to the highest voluntary effort. We urge you to beware of unleashing the forces of fear, passivity, dependence upon materiality and tyrannical bureaucracy which would inevitably plunge us into deeper misery than what you seek, we believe inadvisedly, to relieve by this proposed legislation.

It should be clear from the foregoing statement that our emphasis is not on paying a tax to provide for a national benefit agreed upon by everybody as desirable and realizable, nor indeed on even being doubly taxed as would happen in our case, but on the establishment of a monopoly for one form of healing and on throwing the entire weight of Government both Federal and State behind a program which would inevitably tend to force people to accept and adopt that form of healing. Since that is the result, why not come out into the open and say so frankly in the exhaustive declaration of purpose which prefaces S. 1320?

It would be possible to register objections to many details in S. 1320, but our basic protest is against any massive and for that matter revolutionary program of Federal health activities recognizing only one school or type of healing method. We protest against the propaganda methods used by some governmental agencies in attempting to saddle this revolutionary and inequitable program upon the American people. Methods of administration and organization are secondary to the basic wrongful concepts of compulsion and monopoly. Even though as in an alternative measure now before your committee (S. 545), administrative authority is specifically conferred on the States, and the Federal hand is well concealed, nevertheless the whole tendency is inevitable and therefore objectionable, because it must lead to four results: (1) Increasing and eventually complete centralization of Federal control; (2) designating and limiting aid to only one school of health service, allopathic medicine; (3) shutting off the impetus to thoughtful inquiry into unnumbered ways and means for solving life's problems, including those of health; (4) furthering the dependence upon exterior governmental power and resources instead of encouraging people to look within themselves to stimulate personal initiative, to unlock their own reserves of spiritual power wherewith to find freedom from the evils which this objectionable legislation seeks to combat.

We contend therefore that so long as our country remains free and is not reduced to the status of a regimented society, healing, like education and religion, must remain a matter of voluntary, individual choice and not be arbitrarily confided to any governmental board or commission or bureaucrat, Federal, State, or local, however benevolent or well-intentioned.

LETTER OF ELLEN WINSTON, COMMISSIONER, THE NORTH CAROLINA STATE BOARD OF PUBLIC WELFARE

JUNE 12, 1947.

Senator H. ALEXANDER SMITH,
Senate Office Building, Washington 25, D. C.

DEAR SENATOR SMITH: As we have previously written Senator Taft, we are greatly concerned over certain provisions of the Taft health bill (S. 545) with reference to provisions for medical care of indigents. While we certainly agree with the objective of providing adequate medical care facilities for low-income families, the bill as now worded would run contrary to our present organization in this State. Although the bill provides that such program shall come within a short period of time under States departments of health, in this State the medical care commission receives the State appropriation for hospitalization of the indigent and in turn indigency is certified by the State board of public welfare and its local departments. There is, of course, ample precedent for congressional action which makes possible designation of the appropriate State agency in order to take account of varying developments within States.

We should appreciate having this statement entered in the committee record.

Sincerely,

ELLEN WINSTON.

LETTER OF RABBI STEPHEN S. WISE, PRESIDENT, AMERICAN JEWISH CONGRESS, NEW YORK, N. Y.

HON. H. ALEXANDER SMITH,
Chairman, Subcommittee on Health, Labor and Public Welfare Committee,
Senate Office Building, Washington, D. C.

MY DEAR SENATOR SMITH: Not being able to testify personally, I should like to offer a brief written statement concerning the Taft-Smith-Ball-Donnell bill, S. 545. I am opposed to this bill.

Frankly, this bill has shocked me, because it pretends so much and offers so little. I read on its opening page that it calls itself "The National Health Act of 1947." From this title one would think the bill presented a broad health program that would serve all our people. On the second page of the bill I read "That it is the policy of the United States to aid the States * * * to make available medical, hospital, dental, and public-health services to every individual regardless of race or economic status." From this eloquent preamble one would certainly think that the bill was intended to serve the whole people.

But then, when I turn to the substantive provisions of the bill, what do I find? The money which this bill would appropriate may be spent only for certain selected people, so-called needy people, people whose incomes are so low that they can pay nothing for their medical care, or at most only a part of its cost. In a word, this bill is a bill to extend public medical charity.

God knows there are plenty of needy persons in this country, even in these prosperous years, and some of them live in places where neither private givers, nor the town, county, or State are able to pay sufficiently for their sustenance when they are in distress. I would welcome a law that would place the financial strength of our Nation behind the slim resources of such communities and say to them, "Now you may serve your poor." Doctoring and hospitalization for these persons is only part of their need, though often a very important part. This bill presumably would help such persons, as recipients of public charity. I am told that at the present time this dependent group makes up less than 4 percent of our population.

But this bill sets up the claim that it would help anybody—anybody, that is, who would apply for charity in time of illness, and whose need for charity would have to be proved by some kind of investigation, or means test, or grading of income. It sets up the claim that if we can help such people we have solved the problem of medical care for everybody.

I consider such a pretension to be both mistaken and abhorrent. It is mistaken because the great majority of our people—all those except the few who are already destitute or are really well-to-do—may at any time be faced with unexpected sickness costs which they cannot meet; and a problem, which involves the great majority of our people, cannot be solved by charity. A means test in any form is abhorrent to most Americans. Most of us would delay seeking a doctor until the last extremity if we had to face investigation and financial classification by a public authority, in order that our care should be paid for. The authors of this bill have, I believe, greatly mistaken the temper of the American people in laying down the charity principle as the basis of what they call a national health program.

I am aware that the bill seeks to encourage the health insurance plans that have been started by various medical, hospital, industrial and cooperative organizations. The bill proposes to give aid by paying such plans part or all of the charges in behalf of persons who cannot pay the full charges out of their own resources. Again, it would be necessary to classify people financially. And, even if I could accept this principle, which I cannot, I wonder whether the intricacies of such classification would not prove self-defeating. A man's wage rate is not a stable or necessarily a fair measure of his ability to pay for medical care for himself and his family. Will people wish to join such so-called voluntary insurance plans under these conditions? Or, if the conditions, under which they may join, are made easy by making the means test merely nominal, would not there then be required vastly larger sums from Federal and State taxes than the proposers of this bill offer or would be willing to envisage?

Considering the matter in broad principle, as it is appropriate for me to do rather than to enter into details better handled by experts, I am struck by the contrast between this bill and the National Health Insurance Act, S. 1320. I appeared last year in favor of the principles of this act. This bill is based not upon charity but on self-help. Insurance is self-help. Our Government would be put to work to organize self-help on a scale which only the Government can compass, for a problem in which the whole population is concerned. Most American families accept the obligation to pay their doctors and hospitals, and do pay them. National health insurance means legally sanctioning that obligation, through the democratic procedures of our legislative bodies. And the obligation thus sanctioned would—because the payments out of family earnings would be regular and even—be far less burdensome than unpredictable sickness bills are today. The principle of national health insurance seems to me to be honest, adequate, and expressive of that self-reliance which we like to think of as characteristic of America.

Faithfully yours,

STEPHEN S. WISE.

MEMORANDUM OF SENATOR DONNELL RESPECTING HEARING OF JULY 9, 1947, THIS SUBJECT

MEMORANDUM

Through information from Dr. Marjorie Shearon I have learned that certain contents of my statement on page 1218 of the printed copy of those certain proceedings which occurred on July 9, 1947, in hearings on S. 545 and S. 1320 are incorrect. The purpose of this memorandum is to correct the errors in said statement.

My present understanding is that—

1. No edition of that certain booklet by Dr. Shearon which is entitled "Blueprint for the Nationalization of Medicine" contains, in the chart relating to "Administration Plans for Nationalization of Medicine Emanating From the House of Falk," any of the following-quoted nouns or adjective, namely, "collaborationists, fellow-travelers, appeasers, gullible accepters."

2. No one of the nouns or the adjective quoted as follows, namely "collaborationists, fellow-travelers, appeasers, gullible accepters" was used by Dr. Shearon in a diagram or chart relating to "Administration Plans for Nationalization of Medicine Emanating From the House of Falk" in any document distributed to any person by her or with her approval except—

> (*a*) approximately fifteen photostatic copies of a typewritten diagram or chart and
>
> (*b*) approximately 75 mimeographed copies of a typewritten diagram or chart. which diagram or chart did not, however, contain any of the nouns or the adjective "fellow-travelers, appeasers, gullible accepters," but the caption of which diagram or chart was "Nationalization of Medicine Dominated by the House of Falk—Spheres of Influence, Interlocking Directorates, Collaborationists."

Of said approximately 15 photostatic copies some (perhaps all but one, which one disappeared in Chicago) were mailed by her. Said approximately 75 mimeographed copies of a typewritten diagram or chart were distributed by her sponsors in Denver at or about the time she delivered a speech on March 13, 1946, at Denver.

3. Instead of stating, as set forth on said page 1218:

> The Blueprint does contain the language at the top of the chart: "Administration plans for nationalization of medicine, emanating from the House of Falk. Spheres of influence and interlocking directorates, collaborationists, fellow travelers, appeasers, satellites, and gullible accepters."

I should have stated as follows, namely:

> There occurs, in approximately 15 photostatic copies which were distributed by Dr. Shearon of a typewritten diagram or chart (but not in any edition of the booklet entitled "Blue print for the Nationalization of Medi-

> cine"), the following-quoted caption, namely, "Administration Plans for Nationalization of Medicine Emanating From the House of Falk—Spheres of Influence and Interlocking Directorates, Collaborationists, Fellow-travelers, Appeasers, Satellites, and Gullible Accepters"; and approximately 75 mimeographed copies of a typewritten diagram or chart, which were, with her approval, distributed by the Colorado State Medical Society, contained the following caption, namely "Nationalization of Medicine Dominated by the House of Falk—Spheres of Influence, Interlocking Directorates, Collaborationists."

4. The copy offered by me (in the record at said page 1218) in conjunction with my statement as follows,

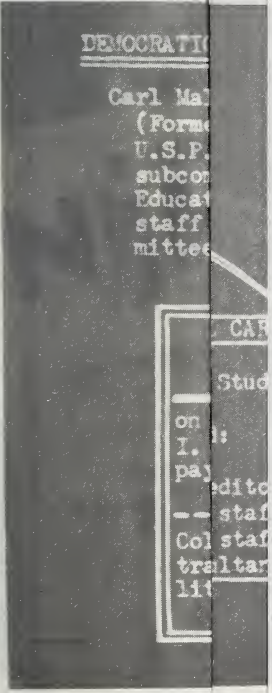
> I call attention to the further fact that it is my information from Dr. Shearon that approximately only 10 of these blueprints were printed, that she does not know how this particular one came into the possession of either Senator Murray or Senator Pepper; but I offer it in the record at this time, Mr. Chairman, a copy taken from the booklet marked "Blueprint for the Nationalization of Medicine," by Marjorie Shearon, Ph. D., research analyst

was by mistake referred to by me as "a copy taken from the booklet marked 'Blueprint for the Nationalization of Medicine' by Marjorie Shearon, Ph. D., research analyst," whereas, in reality, it was one of, or a copy of one of, the approximately 15 photostatic copies, above-mentioned, of a typewritten diagram or chart.

Dated December 24, 1948.

Forrest C. Donnell.

×



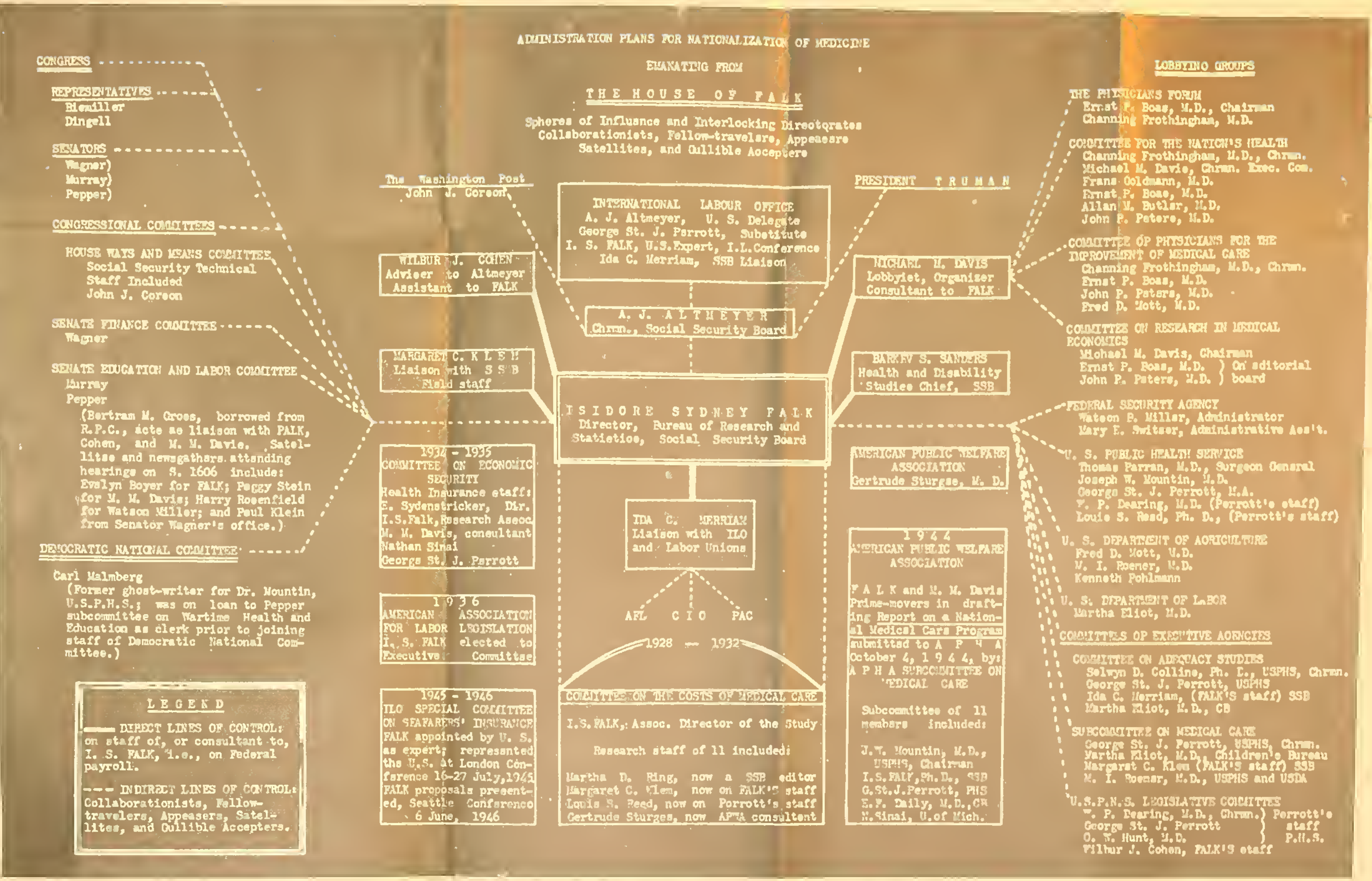
DEMOCRATIC

Carl Ma
(Form
U.S.P.
subco
Educa
staff
mitte

CAR

Stud

on
I.
pay
edit
-- staf
Col staf
traltar
lit



ADMINISTRATION PLANS FOR NATIONALIZATION OF MEDICINE

EMANATING FROM

THE HOUSE OF FALK

Spheres of Influence and Interlocking Directorates
Collaborationists, Fellow-travelers, Appeasers
Satellites, and Gullible Accepters

CONGRESS

REPRESENTATIVES
Biemiller
Dingell

SENATORS
Wagner)
Murray)
Pepper)

CONGRESSIONAL COMMITTEES

HOUSE WAYS AND MEANS COMMITTEE
Social Security Technical
Staff Included
John J. Corson

SENATE FINANCE COMMITTEE
Wagner

SENATE EDUCATION AND LABOR COMMITTEE
Murray
Pepper
(Bertram M. Gross, borrowed from R.P.C., acts as liaison with FALK, Cohen, and M. M. Davis. Satellites and newsgathers attending hearings on S. 1606 include: Evelyn Boyer for FALK; Peggy Stein for M. M. Davis; Harry Rosenfield for Watson Miller; and Paul Klein from Senator Wagner's office.)

DEMOCRATIC NATIONAL COMMITTEE

Carl Malmberg
(Former ghost-writer for Dr. Mountin, U.S.P.H.S.; was on loan to Pepper subcommittee on Wartime Health and Education as clerk prior to joining staff of Democratic National Committee.)

LEGEND

——— DIRECT LINES OF CONTROL: on staff of, or consultant to, I. S. FALK, i.e., on Federal payroll.

- - - INDIRECT LINES OF CONTROL: Collaborationists, Fellow-travelers, Appeasers, Satellites, and Gullible Accepters.

The Washington Post
John J. Corson

INTERNATIONAL LABOUR OFFICE
A. J. Altmeyer, U. S. Delegate
George St. J. Perrott, Substitute
I. S. FALK, U.S.Expert, I.L.Conference
Ida C. Merriam, SSB Liaison

PRESIDENT TRUMAN

WILBUR J. COHEN
Adviser to Altmeyer
Assistant to FALK

A. J. ALTMEYER
Chmn., Social Security Board

MICHAEL M. DAVIS
Lobbyist, Organizer
Consultant to FALK

MARGARET C. KLEM
Liaison with SSB
Field staff

BARKEV S. SANDERS
Health and Disability
Studies Chief, SSB

ISIDORE SYDNEY FALK
Director, Bureau of Research and
Statistics, Social Security Board

1934 - 1935
COMMITTEE ON ECONOMIC SECURITY
Health Insurance staff:
E. Sydenstricker, Dir.
I.S.Falk, Research Assoc.
M. M. Davis, consultant
Nathan Sinai
George St. J. Perrott

AMERICAN PUBLIC WELFARE ASSOCIATION
Gertrude Sturges, M. D.

IDA C. MERRIAM
Liaison with ILO
and Labor Unions

AFL
C I O
PAC

1936
AMERICAN ASSOCIATION FOR LABOR LEGISLATION
I. S. FALK elected to Executive Committee

1945 - 1946
ILO SPECIAL COMMITTEE ON SEAFARERS' INSURANCE
FALK appointed by U. S. as expert; represented the U.S. at London Conference 16-27 July, 1945
FALK proposals presented, Seattle Conference 6 June, 1946

1928 — 1932

COMMITTEE ON THE COSTS OF MEDICAL CARE

I.S.FALK, Assoc. Director of the Study

Research staff of 11 included:

Martha D. Ring, now a SSB editor
Margaret C. Klem, now on FALK'S staff
Louis S. Reed, now on Perrott's staff
Gertrude Sturges, now APHA consultant

1944
AMERICAN PUBLIC WELFARE ASSOCIATION

FALK and M. M. Davis
Prime-movers in drafting Report on a National Medical Care Program
submitted to A P H A
October 4, 1944, by:
A P H A SUBCOMMITTEE ON MEDICAL CARE

Subcommittee of 11 members included:

J. W. Mountin, M.D., USPHS, Chairman
I.S.FALK, Ph.D., SSB
G.St.J.Perrott, PHS
E.F. Daily, M.D., CB
N.Sinai, U.of Mich.

LOBBYING GROUPS

THE PHYSICIANS FORUM
Ernst P. Boas, M.D., Chairman
Channing Frothingham, M.D.

COMMITTEE FOR THE NATION'S HEALTH
Channing Frothingham, M.D., Chmn.
Michael M. Davis, Chmn. Exec. Com.
Franz Goldmann, M.D.
Ernst P. Boas, M.D.
Allan M. Butler, M.D.
John P. Peters, M.D.

COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE
Channing Frothingham, M.D., Chmn.
Ernst P. Boas, M.D.
John P. Peters, M.D.
Fred D. Mott, M.D.

COMMITTEE ON RESEARCH IN MEDICAL ECONOMICS
Michael M. Davis, Chairman
Ernst P. Boas, M.D.) On editorial
John P. Peters, M.D.) board

FEDERAL SECURITY AGENCY
Watson B. Miller, Administrator
Mary E. Switzer, Administrative Ass't.

U. S. PUBLIC HEALTH SERVICE
Thomas Parran, M.D., Surgeon General
Joseph W. Mountin, M.D.
George St. J. Perrott, M.A.
F. P. Dearing, M.D. (Perrott's staff)
Louis S. Reed, Ph. D., (Perrott's staff)

U. S. DEPARTMENT OF AGRICULTURE
Fred D. Mott, M.D.
M. I. Roemer, M.D.
Kenneth Pohlmann

U. S. DEPARTMENT OF LABOR
Martha Eliot, M.D.

COMMITTEES OF EXECUTIVE AGENCIES

COMMITTEE ON ADEQUACY STUDIES
Selwyn D. Collins, Ph. D., USPHS, Chrmn.
George St. J. Perrott, USPHS
Ida C. Merriam, (FALK'S staff) SSB
Martha Eliot, M. D., CB

SUBCOMMITTEE ON MEDICAL CARE
George St. J. Perrott, USPHS, Chrmn.
Martha Eliot, M.D., Children's Bureau
Margaret C. Klem (FALK'S staff) SSB
M. I. Roemer, M.D., USPHS and USDA

U.S.P.H.S. LEGISLATIVE COMMITTEE
F. P. Dearing, M.D., Chrmn.) Perrott's
George St. J. Perrott } staff
O. K. Hunt, M.D. } P.H.S.
Wilbur J. Cohen, FALK'S staff

Library
National Institutes of Health
Bethesda 14, Maryland

LIBRARY
NIH
Amazing Research.
Amazing Help.
http://nihlibrary.nih.gov

10 Center Drive
Bethesda, MD 20892-1150
301-496-1080

NIH LIBRARY
4 0110 5822

NIH LIBRARY
3 1496 00180 8263